Know Your Benefits

Version 01

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A company of the Principal Financial Group

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FY 2007 - 2008
Maricopa County Employee Benefit Plan

eHi
EMPLOYEE HEALTH INITIATIVES

Envision living "well" into the future...

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The Information in this booklet highlights the Maricopa County benefit plans for employees and their dependents.

This booklet is intended to provide you with information needed to make informed decisions regarding the selection of your benefits. The benefits described herein are summaries of the County's official plan documents and contracts that govern the plan. In the event of a discrepancy between the information in this booklet and the official documents, the official documents govern.
Maricopa County reserves the right to change or cancel its benefit plans, in whole or in part, at any time.

Participation in any of the County's benefit plans is not a contract of employment.

HOW TO OBTAIN BENEFIT INFORMATION

Information about the benefit plans is available on the Internet at ***www.maricopa.gov/benefits*** or on the Electronic Business Center (EBC)/Intranet at ***ebc.maricopa.gov/ehi***.

(Both of these Web sites are referred to as the Employee Health Initiatives or EHI Home Page in this document.)

You may also e-mail the EHI Department at ***BenefitsService@mail.maricopa.gov*** or, for enrollment and plan information, call 602-506-1010 from 8 a.m. to 5 p.m. MST Monday- Friday or visit the EHI Department located at 301 West Jefferson Street, Suite 201, Phoenix.

The EHI Department can assist you with general questions related to premiums, eligibility and enrollment, status changes, and benefits continuation while on or returning from a leave of absence (LOA) and/or upon retirement.

Please contact the specific vendor for answers to detailed benefit questions regarding coverage, costs and claim(s) payments. Vendor contact information is located in the "Who to Contact" section of this booklet.

The words "you" and "your," when used in this document, refer to the employee.

GLOSSARY OF TERMS

Co-insurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will assume a percentage of the costs of covered services after payment of the deductible, if applicable.

Copay: A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as $20 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of cost.

CMG (CIGNA Medical Group): A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG facilities that are owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG facilities. Some specialty care is provided through the OAP network when a referral is made by the CMG physician.

CMG High and Low Plan: A managed-care plan that requires members to use the CMG network for primary and most specialty and other services. Use of non-network providers or providers in private practice is not covered.

Deductible(s): Under a health insurance policy, amounts required to be paid by the insured either before benefits become payable, after a portion of benefits have been paid or for a specific benefit, before benefits are payable.

Flexible Spending Account (FSA): A plan which provides employees with a way to set aside money on a pre-taxed basis to cover the costs of either health care expenses that are not covered under their health insurance coverage (medical, pharmacy, mental health, dental and vision) or dependent care expenses that enable the employee to work.

Group Insurance Qualified Status Change Form: An official document generated by the EHI Department on which the employee requests a change to benefit elections due to a qualified status change.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals and other health professionals, who participate in their network. The members of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

Health Savings Account: A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

High Option: A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

In-Network (or Network, Participating Provider): Health care provided by a doctor, hospital, pharmacy or other health care provider with whom the plan has contracted to provide services at specified fees. Under the CIGNA CMG and OAPIN plan, the insured must choose a network primary care physician and have care coordinated by the PCP to qualify for payment of benefits.

Insured: A person or organization covered by an insurance policy.

Insurer (Insurance Company): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Low Option: A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and co-insurance.

Medical Waiver Payment: Compensation paid to the employee by the County if medical coverage is not elected because of enrollment in other eligible group health insurance. Waiving medical coverage means waiving coverage for all components of the medical plan, which includes medical, vision, pharmacy, and behavioral health and substance abuse benefits.

OAP (Open Access Plus) Plan: A plan that gives options to use a network or non-network physician/provider each time the insured needs medical care, and requires no referral to see a specialist.

OAPIN (Open Access Plus) In-Network: A plan that uses a network of providers who practice in their own private practice offices and independently contract with CIGNA. Non-network physicians/providers may not be used with this plan. The OAP In-Network also includes the CMG network. No referral is required to see a specialist.

Out-of-Network (or Non-Participating, Non-Network Provider): Health care received from a provider who is not contracted with the insured's health plan network, or, if a primary care provider is required, care that is not referred by the insured's primary care provider and their health plan.

Out-of-Pocket Maximum: The maximum amount the insured pays each year for health care. The maximum may apply only to specific services such as inpatient hospitalizations. After this share of eligible expenses has reached the plan's out-of-pocket limit per person or per family, the plan pays the full cost of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any copays, pharmacy or mental health/substance abuse treatment expenses, or non-certification penalties.

Plan Year: July 1 through June 30

Preferred Medication List (aka Formulary): List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred medication list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class.

Primary Care Physician (PCP): A physician who practices general medicine, family medicine, internal medicine or pediatrics.

Reasonable and Customary Charge (R&C): The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives out-of-network services and the provider's fee is more than the R&C charge, the insured will have to pay the amount of charges above R&C. When network care is received, the eligible expenses are determined from the network provider's contracted rate.

Short-Term Disability (STD) benefits: STD pays a percentage of the insured's salary if he/she becomes temporarily disabled due to sickness or injury and is not able to perform the essential functions of his/her job. The insured must be under the regular care and treatment of an appropriate provider. An STD policy provides a weekly portion of the insured's salary for up to 23 weeks.

Term Life Insurance: Term life insurance covers a person for death benefits for a limited time (a term). In the case of the term life insurance coverage provided by The Standard, the term is conditional. You are covered as long as you are employed by Maricopa County. Term life insurance does not have any cash value.

GLOSSARY OF ACRONYMS

Abbreviations used throughout this booklet

A
AD&D: Accidental Death & Dismemberment
AHCCCS: Arizona Health Care Cost Containment System
ARS: Arizona Revised Statutes
ASI: Application Software, Inc.
ASRS: Arizona State Retirement System

C
CMG: CIGNA Medical Group
COBRA: Consolidated Omnibus Budget Reconciliation Act

E
EAP: Employee Assistance Program
EBAC: Employee Benefits Advisory Council
EBC: Electronic Business Center (Intranet)
EDS: Employers Dental Services
EE: Employee
EHI: Employee Health Initiatives
EOI: Evidence of Insurability

F
FMLA: Family Medical Leave Act
FML: Family Medical Leave
FSA: Flexible Spending Account

H
HIPAA: Health Insurance Portability and Accountability Act
HMO: Health Maintenance Organization
HR: Human Resources
HSA: Health Savings Account

I
ID: Identification
IRC: Internal Revenue Code
IRS: Internal Revenue Service

L
LOA: Leave of Absence

M
MH: Mental Health
MST: Mountain Standard Time

N
NAIC: National Association of Insurance Commissioners
NEO: New Employee Orientation
NRS: Nationwide Retirement Solutions

O
OAPIN: Open Access Plan In-Network
OAP: Open Access Plan
OE: Open Enrollment

P
PCP: Primary Care Physician
PHI: Protected Health Information
PML: Preferred Medication List
PPO: Preferred Provider Organization
PSPRS: Public Safety Personnel Retirement System
PST: Pacific Standard Time
PTO: Paid Time Off

R
RIF: Reduction in Force
RX: Prescription

S
SPD: Summary Plan Document
SSN: Social Security Number
STD: Short-Term Disability

U
UV: Ultraviolet

W
WHI: Walgreens Health Initiatives

INTRODUCTION

Maricopa County recognizes your valuable contributions as an employee by offering comprehensive benefits for you and your dependents through the Employee Benefit Plan. Maricopa County is committed to helping you handle the high costs of health care, the risks of lost income due to illness and disability, and preparing for a secure retirement. The County's benefit plan provides:

Health, Life, Disability & Flexible Spending Accounts

- A choice of six medical plans;
- A choice of two pharmacy plans (unless you elect the high-deductible health plan);
- A vision plan;
- A behavioral health and substance abuse plan;
- A choice of three dental plans;
- Basic and additional life, basic and voluntary accidental death and dismemberment, and dependents life and accidental death and dismemberment insurance plans;
- A short-term disability (STD) plan; and
- Health care and dependent care flexible spending accounts (known as Mariflex).

Other programs and services available to you as an employee include:

- An employee assistance plan (EAP);
- A deferred compensation plan;
- Discounts on auto, home and renters insurance;
- A group legal plan;
- Arizona State Retirement System (ASRS) retirement plan, which include a long-term disability benefit, or Public Safety Personnel Retirement System retirement plan. If you meet eligibility criteria, you must be enrolled in and contribute to the applicable retirement plan.

Who's Eligible?

You can participate in the health, life, disability plans and the flexible spending accounts if you are a regular employee (except some contract employees as specified below) scheduled to work at least 20 hours per week.

For benefit plan purposes, "regular employee" is defined as a full-time or part-time employee who is not temporary, but who may be a contract employee. (When related to benefits administration, the definition herein of a regular employee differs from that which is used in the Merit Rules, available online at ***http://ebc.maricopa.gov/pp/hr/tocs/EmpMerit_TOC.asp***.)

Employees working under specific contracts may or may not be eligible for benefits based on the terms of their contract. Each appointing authority determines if contract employees are benefit eligible.

Those regular employees (except some contract employees as described above) who are scheduled to work less than 20 hours per week and all temporary employees are not eligible to participate in the health, life, disability plans and the flexible spending accounts. Health plans include medical, pharmacy, vision, behavioral health and substance abuse, and dental coverage.

Are Dependents Eligible?

Your legal spouse (does not include common-law, domestic partner, or significant other) and/or your unmarried dependent child(ren) are eligible for coverage under your medical, dental and/or dependents life and accidental death and dismemberment insurance plans. Dependent child(ren) must meet the IRS definition of dependent children pursuant to IRC Section 152 and Maricopa County eligibility requirements.

The term "child" means your unmarried natural child, stepchild, legally adopted child, child placed with you for adoption or child for whom you have been awarded legal guardianship. The term "dependent" means a child who meets one of the relationships listed above, and who meets the following criteria.

Dependent child(ren) under 19 or under 25 (if full-time student) is subject to all of the following:

1. Must be unmarried;
2. Must reside with the employee for more than one-half of the taxable year (January – December);
    a. Temporary absences due to school attendance do not violate this residency rule.
    b. Qualified Medical Child Support Orders or other court/administrative orders do not violate this residency rule.
    c. Your student dependent child will remain eligible during summer breaks from school provided that he/she will be attending school on a full-time basis during the fall term/semester.

3. Must be under age 19, or a full-time student and under age 25, or any age if permanently and totally disabled;
    a. For a child 19 or older, to be deemed a full-time student, the school he/she attends must be an accredited institution for higher education and the child must be attending on a full-time basis. The school will define and determine full-time student status.
    b. For a child who is permanently and totally disabled, the child must have been medically certified as permanently and totally disabled prior to his/her 19th birthday (or prior to his/her 25th birthday if disabled while a full-time student).
4. There is no income limit that the dependent child can earn.

Additional rule for dependent child(ren) age 19 or under age 24 and a full-time student

The child must not have provided more than one-half of his/her support during the taxable year (January – December).

Additional rule for dependent child(ren) age 24, but under age 25 and a full-time student

The child must not have received more than one-half of his/her support during the taxable year (January – December) from the employee.

Verification of continued eligibility as a student or disabled child

You must provide verification of continued eligibility as a student or disabled dependent child to the EHI Department at the beginning of each semester for students and as requested for disabled dependent children. Additionally, the medical, dental and life insurance vendors will ask you to provide verification of student dependent status and/or disabled child eligibility. Failure to provide such verification will result in termination of dependent coverage. Should your child not return to full-time student status at the fall term/semester, the child will be deemed retroactively ineligible on the last day of the pay period after the child's last day of school.

You are responsible for ensuring that only eligible dependents are enrolled and immediately notifying the EHI Department when your dependents become ineligible. **You will be liable and responsible for all claims incurred by your dependent after his/her termination date. Failure to notify the EHI Department within 30 calendar days of ineligibility forfeits the dependent's rights to COBRA coverage continuation.**

WHEN DOES COVERAGE BEGIN FOR NEWLY ELIGIBLE EMPLOYEES?

You have 30 calendar days from your eligibility date to elect and submit your benefit elections online through Employee Self Service at ***my.maricopa.gov***, if you are a new hire, or on a custom enrollment form generated by PeopleSoft if you have changed employment status, and such change resulted in going from benefit ineligible to benefit eligible. To prevent a retroactive premium adjustment to your paycheck and to preserve your choice of benefits, online enrollment should be completed and submitted as soon as possible. Premium starts accruing on your coverage effective date.

New Hire

Benefit coverage for a newly hired employee begins the first day of the month following the date of hire except for Mariflex coverage, which begins on the date his/her election is processed by the EHI Department. Benefit coverage for a re-hired employee with a break of employment of less than 30 calendar days begins the first day of the pay period following benefit termination. Benefit deductions begin the first day of the pay period in which the coverage effective date falls.

Benefit Ineligible to Benefit Eligible

Benefit coverage for an employee whose change in employment status renders him/her benefit eligible begins on the date on which he/she became benefit eligible, except for Mariflex coverage, which begins on the date his/her election is processed by the EHI Department. Benefit deductions begin the first day of the pay period in which the coverage effective date falls.

Default Coverage

If you do not complete enrollment online through Employee Self Service or on a custom enrollment form generated by PeopleSoft within 30 calendar days of your hire date or your change of appointment date, your medical coverage will default to the CIGNA CMG Low Option plan as a tobacco user and your pharmacy coverage will default to the Consumer Choice plan for employee only coverage. Your basic life insurance coverage will be one times your annual salary rounded up to the next thousand. Your default coverage will be effective on the first day of the month following your date of hire for new hires or the date of your change of appointment.

Can I change my benefits once I've made my benefit elections?

After benefit elections have been submitted online through Employee Self Service or on a custom enrollment form generated by PeopleSoft, no change (e.g. additions or deletions of covered dependents) in benefits will be allowed until the next open enrollment period, unless you have a qualified status change as defined under the IRC Section 125. If you were employed by Maricopa County,

terminated employment and then were re-hired within 30 calendar days, the benefit elections in place before your termination will be reinstated, with no option of changing your elections. Refer to the following sections in this booklet for more information: "When Can Changes Be Made & When Are They Effective?" and "What is a Qualified Status Change?"

Open enrollment occurs at times designated by the EHI Department. The next open enrollment will be April, 2008 with benefit elections being effective on July 1, 2008. Open enrollment dates are posted in advance on the EBC/Intranet and communicated to each department via e*Nouncements. Please check with your department HR Liaison, Employee Benefits Advisory Council (EBAC) member or the EHI Department to obtain specific dates of the next open enrollment period.

WAIVING INSURANCE COVERAGE

Waiving medial insurance package

If you do not want coverage under the County's medical insurance package and you are covered under other medical insurance (group or individual insurance including AHCCCS), you may waive coverage under the County's plan by submitting your request via Employee Self Service, on a Group Insurance Qualified Status Change Form or on a custom enrollment form generated by the PeopleSoft system and providing annual documentation of the other medical coverage to the EHI Department. The documentation must identify you as a covered member, the name of the primary insured, the insurance company name, address, fax or phone number, group name and number, if applicable, member identification number and coverage effective date.

If you elect to waive the medical insurance coverage, you relinquish coverage offered through the County's medical package, which includes medical, behavioral health, vision, and pharmacy benefits. However, Maricopa County offers separate vision plan coverage to employees who elect to waive the medical insurance package. Refer to the "Vision Benefit Plan" section for premiums for "Vision without Medical Plan".

Should you decide to waive your coverage because you are covered under eligible group medical insurance, you may qualify for compensation.

Compensation for waiving medical insurance package

The County will compensate you $62.50 the first and second paychecks of each month if you are scheduled to work at least 30 hours a week or if you are a contract employee with full-time benefits and you waive medical coverage because you have coverage under other group medical insurance. In no case is a payment made for the third paycheck of the month or if you do not have hours reported during a pay period.

You are required to provide annual proof of other group medical insurance coverage (as described in the above sub-section) to qualify for the medical waiver payment. Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group medical insurance coverage for this purpose and therefore does not qualify you to receive the medical waiver payment.

Waiving other insurance coverage when newly eligible

You may elect to waive any or all of the following when you are newly eligible. However, election into the plans following your initial eligibility date is limited.

Short-term Disability: You must wait until the next scheduled open enrollment to elect coverage.

Dental Insurance: You must wait until the next scheduled open enrollment period to elect coverage, unless you experience a qualified status change. Refer to "What Coverage Changes Can I Make During the Plan Year?" section.

Additional Life: You may elect or apply for coverage during the plan year. See "Additional Life and Voluntary Accidental Death and Dismemberment (AD&D) Insurance" sub-section in the "Life Insurance Plan" section for further details.

Dependent Life: You may elect this coverage if you experience a qualified status change. Refer to the "What Coverage Changes Can I Make During the Plan Year?" section.

Mariflex Flexible Spending Accounts: You must wait until the next scheduled open enrollment to elect coverage, unless you experience a qualified status change. Refer to the "What Coverage Changes Can I Make During the Plan Year?" section.

HOW TO ENROLL WHEN YOU'RE NEWLY ELIGIBLE

You should attend a New Employee Orientation (NEO) meeting to receive benefit plan information. You can complete your enrollment within 30 calendar days of the event either online through Employee Self Service at ***my.maricopa.gov*** if you are a new hire or via a custom enrollment form generated by PeopleSoft if you have a change in appointment. Instructions on how to enroll online are located on the EBC Intranet at ***http://ebc.maricopa.gov/training/OLL/peoplesoft.asp***. Brief instructions are provided in the "Online Employee Self Service" section. It is in your best interest to complete and submit your online enrollment or custom enrollment form as soon as possible. Refer to the "When Does Coverage Begin for Newly Eligible Employees?" section for more information.

If you are not scheduled to attend a NEO meeting, you have the following additional enrollment options:

1. Ask your Department's HR Liaison for enrollment materials.
2. Go online to the EHI Home Page to obtain the benefit plan information you need to make your choices.
   a. The EBC/Intranet address is: ***http://ebc.maricopa.gov/ehi/***
   b. The Internet address is: ***http://www.maricopa.gov/benefits***
3. Contact the EHI Department via Outlook e-mail at ***BenefitsService@mail.maricopa.gov***.
4. Call the EHI Department for information at 602-506-1010.
5. Visit the EHI Department at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003.

WHO PAYS FOR BENEFIT COVERAGE?

Employer contribution

Maricopa County makes a generous contribution toward the cost of your medical and dental plans. You have the option of selecting medical coverage from CIGNA, pharmacy coverage from Walgreens Health Initiatives, and to select dental coverage from one of three dental vendors: Employers Dental Services (EDS), Delta Dental or CIGNA Dental. The medical plans are described in the "Medical Plans" section. The dental plans are described in the "Dental Plans" section.

If you are normally scheduled to work 30 or more hours per week, you will receive the maximum Maricopa County contribution towards your premium for the CIGNA medical packages (medical, vision, pharmacy, and behavioral health) for you and your dependents. You pay the "Full-time Premium".

If you are scheduled to work 20 to 29.99 hours per week and enroll with CIGNA CMG Low Option medical package (medical, vision, and behavioral health) and Consumer Choice pharmacy plan, you will receive the maximum Maricopa County contribution toward your premium for you and your dependents. You pay the "Full-time Premium".

If you are scheduled to work 20 to 29.99 hours per week and enroll in any of the other medical package combinations (medical, vision, pharmacy, and behavioral health), you will receive a **lower** Maricopa County contribution toward your premium for you and your dependents. You pay the "Part-time Premium".

The County contributes the same amount toward your dental elections for the EDS plan regardless of your weekly scheduled hours. If you are scheduled to work 20 to 29.99 hours per week and elect dental coverage through Delta Dental or CIGNA Dental, the County contribution is lower. You pay the "Part-time Premium". If you are scheduled to work 30 or more hours per week, you pay the "Full-time Premium".

Employee contribution

When you elect benefits, you authorize the County to deduct the current employee benefit premiums from your paycheck for each benefit option you elect. Payroll deductions will be made from the first two paychecks of each month, 24 paychecks per year. However, since there are 26 paychecks per year, two paychecks have no benefits deductions, with the exception of those for the Mariflex flexible spending accounts and the health savings account (associated with the CIGNA Choice Fund high-deductible health plan) for which deductions are taken every paycheck, or if you have a balance due in arrears for any of the other benefits (medical, dental, life, etc.).

If at any time you do not receive a paycheck for a pay period that results in no premium payment by either you or your department, you are responsible for notifying the EHI Department immediately to arrange for alternate premium payment options.

If payment is not made within 60 calendar days of the coverage period begin date, your benefit coverage will be terminated due to non-payment of premium. You will then be offered COBRA continuation coverage.

You are responsible for reviewing your paycheck to verify that the correct premium deduction amounts are taken for the benefit options you elected. Please refer to the premium rates in the "Pay Period Premium Rates" section.

If the premium deductions on your paycheck are incorrect in that you have been charged a higher amount due to an administrative error, and you identify the problem in writing to the EHI Department within six months from the date the error began, your premiums will be adjusted retroactively to reflect the correct amounts from the date of the error and refunded to you and your department, at the department's request. Incorrect premium payments resulting from you not notifying the EHI Department within 30 calendar days to remove an ineligible dependent will not be refunded to you or your department until a full claims audit has been conducted to determine your liability. Administratively caused premium errors discovered after six months will be corrected on a prospective basis with no refund on the overpaid premium to you or your department.

Regardless of when an error is discovered, if your premium deduction is incorrect in that you have been charged a lower amount than you should have paid, your premiums will be adjusted retroactively to the date of the occurrence and you and your department will be responsible for the cost of the underpaid premiums.

Deductions for the medical package (medical, vision, pharmacy, and behavioral health), dental and health care and/or dependent care FSAs reduce your taxable income, thus saving you money that would otherwise be paid in taxes. This tax advantage is provided under and follows the provisions of IRC Section 125.

DO BENEFITS CONTINUE WHILE ON AN UNPAID LEAVE OF ABSENCE?

General

When you take an approved unpaid leave of absence (LOA) (e.g. personal, medical or military leave) from your position, you must continue to pay your portion of the premiums for your benefits, such as medical and dental, and the full premium amount for additional and dependents life insurance, short-term disability (STD) and other voluntary benefits in order to continue coverage.

If you do not elect to continue by completing a Payment Agreement or you do not revoke your benefits by completing a Group Insurance Qualified Status Change Form within 30 calendar days from the beginning date of your unpaid LOA, and if your leave lasts for less than 30 days, the EHI Department will assume that you want to continue your benefits and you will be liable and responsible for paying your portion of all your premiums and your FSA annual pledge while on a LOA. Upon your return to work, your unpaid premiums will be deducted from your paychecks in amounts calculated in accordance with the EHI Department arrears procedure. Your FSA annual pledge will be recalculated to fully deduct the remaining portion of your annual pledge through the remaining pay periods in the benefit plan year. If you terminate employment voluntarily or involuntarily, and you have not paid your overdue premiums, you will be subject to collection action.

Military Leave

If you are going on military leave, refer to the Military Leave policy HR2417 available online at ***http://ebc.maricopa.gov/pp/hr/pdf/h2417.pdf***. This policy requires you to complete a Notification of Uniformed Service Form indicating your intention to waive or continue benefits. Contact your department's HR Liaison to obtain this form. Complete and return this form to your HR Liaison, who will send it to Employee Records. If this form is not completed, your benefits will terminate. Before the military leave begins it is advisable that you work with your HR Liaison to update your contact information such as your address and phone number and provide a person's name and phone number who may be contacted in your absence.

Subject to and in conformance Military Leave Policy HR2417, USERRA and 10 U.S.C. § 1071 et. seq, employees who are members of the uniformed services have the option of obtaining medical and dental benefits for themselves and their dependents through the military health care system or may choose to continue their health and other benefits (restrictions apply to life insurance which must be converted 90 days following the date the military leave of absence began) through Maricopa County's Employee Benefit Plan at the active employee premium rate for a period of one year to begin when the employee is placed on Leave Without Pay after the commencement of active duty. To continue coverage through the Plan, the employee must notify the EHI Department within 30 calendar days of his/her unpaid leave, complete the Notification of Uniformed Service Form and make timely premium payments.

Upon conclusion of the one year coverage period, the employee is entitled to continue coverage through the Plan for an additional six months with the employee paying the entire cost of the premiums. Following this 18-month period, a COBRA notice will be mailed to the employee at his/her address on file in the PeopleSoft system.

Life Insurance

Since Maricopa County pays 100% of the premium for your basic life coverage, it will continue in force while you are on an approved unpaid LOA as follows:

- If you are not working due to injury or sickness, injury or pregnancy, you can continue to be covered through the end of the pay period following 180 days from the date your approved, unpaid leave status began.
- If you are on a military leave of absence, you will be covered through the end of the pay period following 90 days from the date your military leave of absence began.
- If you are on an approved personal leave of absence, you will be covered through the end of the pay period following 90 days from the date your leave of absence began.

If your leave extends past the coverage end date above and you wish to continue your basic, additional and/or dependents life coverage, you may elect conversion coverage for yourself and your dependents at a higher premium rate. You and a representative of the EHI Department must complete portions of the application for Conversion of Group Insurance. Refer to the "Life Insurance Plan" section for more details and the time frame in which the form and the premium are due.

Discontinue coverage while on LOA

If you do not wish to continue some or all of your benefits, you must revoke coverage by completing a Group Insurance Qualified Status Change Form within 30 calendar days of the beginning date of your unpaid LOA. However, your STD coverage may not be revoked, unless you are part of a Reduction in Force (RIF) and chose RIF Option 2 or you are on military leave. Contact the EHI Department or go online to ***http://ebc.maricopa.gov/ehi/*** to the Forms link to obtain a Group Insurance Qualified Status Change Form.

Refer to the "Return from LOA/Reinstatement of Benefits" sub-section for information on what process to follow in order for benefits to be reinstated upon your return to work.

Continue coverage while on LOA

If you want to continue your benefit coverage, you must complete a Payment Agreement Form with the EHI Department in advance of your leave, if possible, to decide on premium payment and coverage options while you are on an approved LOA. If advance notice is not possible due to your medical condition or other extenuating circumstance, the agreement must be made within 30 calendar days of your leave beginning date.

The following payment options are available and consistent with the federal laws governing cafeteria plans, Family Medical Leave Act (FMLA) and USERRA. Contact the EHI Department, Finance Unit at (602) 506-1010 to advise which payment plan you are selecting.

- Pre-pay with pre-tax dollars for coverage periods within the current and/or new plan year, if you have sufficient taxable earnings.
- Pre-pay with after-tax dollars.
- Pay as you go. Payments must be made on a monthly basis.
- Pay as you go. Payments will be deducted on a pro-rated daily basis from your short-term disability payment.

Premium payment while on LOA

You must continue to pay your portion of the insurance premiums in a timely manner as described above for coverage to continue. The County will not pay its portion of the premium for medical and dental coverage until your full monthly payment is received.

If your premium is not paid within 60 calendar days following the due date, your benefits will be terminated retroactive to the last day of the pay period for which premiums were paid. **When coverage is terminated, you are liable and responsible for all claims incurred after your termination effective date**. Refer to the "Return from LOA/Reinstatement of Benefits" sub-section for information on what process to follow in order for benefits to be reinstated upon your return to work.

Note: If you are receiving STD, your payments for benefit premiums will be deducted from your STD payments on a prorated daily basis unless your Payment Agreement Form otherwise specifies. On a monthly basis, the EHI Department will audit your account to verify premium payments equal the amount due. If the audit results in a premium due, the EHI Department will send you a billing statement. Payment of such premium is due within 15 days from the date of the statement. A refund of any partial premiums you paid will be returned to you within 30 calendar days from the completion of the premium audit.

As a convenience while you are on LOA, the EHI Department will accept premium payments through Visa or MasterCard. To make your payments in this manner, please contact the EHI Department with your credit card information each month.

Upon receipt of your portion of the monthly premium, the County will make its contribution to medical and dental premiums for you and your dependents while you are on an approved **personal LOA** for up to three months of premiums (6/24ths of the annual premium) in a rolling 12-month period starting the first day of your unpaid leave.

Upon receipt of your portion of the premium, the County will make its contribution to medical and dental premiums for you and your dependents while you are on either an **approved Family Medical Leave Act (FMLA) or non-FMLA medical LOA** for up to six months of premiums (12/24ths of the annual premium) in a rolling 12-month period starting the first day of your unpaid leave.

Note: County contributions toward your medical and dental premiums may not extend beyond six months (12/24ths of the Annual Premium) in a rolling 12-month period by combining a personal leave with a medical leave. If you do not return to work after your FMLA leave entitlement has been exhausted or expires, **in certain situations the County may recover from you** the portion of medical and dental premiums it paid on your behalf while you were on such LOA, in accordance with federal regulations 29 CFR 825.213.

Continuation of coverage beyond county benefit eligibility

If you continue on an approved unpaid LOA beyond the point at which the County's contribution ends or if you terminate or resign employment (either voluntarily or involuntarily), you become ineligible for the County contribution to your medical and dental benefits. (However, if you are included in a RIF, you may be eligible to continue your benefits according to the HR2403 Reduction in Force Policy.) You may be eligible for continuation of coverage under COBRA of 1985.

A COBRA notice containing enrollment and premium information will be mailed to you at your address on file in the PeopleSoft system if you become ineligible for County contributions toward your benefits. By enrolling in COBRA coverage within the designated period and paying the total monthly premiums and administrative charge, coverage for your health care benefits [medical (pharmacy, vision and behavioral health), dental, vision only, and/or health care FSA] will continue retroactive to the date of ineligibility without a break in coverage through the period of COBRA eligibility.

If you are receiving a payment for short-term disability, your premium for short-term disability coverage will continue to be deducted from your short-term disability payment.

Refer to the "Life Insurance Plan" section for conversion or portability coverage continuation information.

LOA 30 days or less

If you do not elect to continue coverage by completing a Payment Agreement or you do not revoke your benefits by completing a Group Insurance Qualified Status Change Form within 30 calendar days from the beginning of your unpaid LOA, and if your leave lasts 30 calendar days or less, the EHI Department will assume that you want to continue your benefits and you will be liable and responsible for paying your portion of all your premiums and your Mariflex FSA annual pledge. Upon your return to work, one pay period's premium arrearage will be deducted from each paycheck until the unpaid premium is recovered. Your FSA annual election will be recalculated to fully deduct the remaining portion of your annual pledge through the remaining pay periods in the benefit plan year.

LOA greater than 30 days

If you do not revoke your benefits by completing a Group Insurance Qualified Status Change Form or Notification of Uniformed Service Form within 30 calendar days of the beginning of your unpaid leave, you do not elect to continue coverage by completing a Payment Agreement, your leave lasts more than 30 calendar days and you have not paid your premium(s) within 60 days, the EHI Department will terminate your coverage retroactively to the end of the last day of the pay period in which premiums were paid. **You will be liable and responsible for all claims incurred after your termination effective date**.

If you return to work, your FSA annual pledge will be recalculated to fully deduct the remaining portion of your annual pledge through the remaining pay periods in the plan year.

If you terminate employment and you have not paid your overdue premiums, your benefits will be terminated retroactively to the end of the last day of the pay period in which premium was paid. **You will be liable and responsible for all claims incurred after your termination effective date**.

Note: In any case where your premium payments are not current, the insurance carrier may interrupt and/or terminate your benefits.

Return from LOA greater than 30 days/Reinstatement of benefits

If coverage is terminated because of premium non-payment or revocation of benefits during your LOA, coverage may be reinstated upon your return to benefit-eligible active employment status if you complete a Group Insurance Qualified Status Change Form within 30 calendar days of returning. Failure to complete a Group Insurance Qualified Status Change Form within the 30-day period will result in loss of benefits for the remainder of the plan year. Refer to the "When Can Changes Be Made & When Are They Effective?" section.

WHEN DOES COVERAGE END?

Coverage ends the last day of the pay period in which you and/or your covered dependents cease to be eligible for coverage or for which a premium was paid, whichever comes first. **When coverage ends, you are liable and responsible for all claims incurred after your last day of coverage.**

You are responsible for notifying the EHI Department when a dependent no longer meets the eligibility requirements listed in the "Are Dependents Covered?" section. If you fail to notify the EHI Department within 30 calendar days of ineligibility, medical, other benefit expenses and administrative costs paid or incurred on behalf of an ineligible dependent become your liability and responsibility from the beginning date of ineligibility. Additionally, your dependent will lose eligibility to continue coverage under COBRA.

If you and/or your covered dependents cease to be eligible for medical or dental insurance or the health care FSA and you notify the EHI Department of such ineligibility within 30 calendar days, a COBRA notice containing enrollment and premium information will be mailed to you and/or your dependent at your address on file in the PeopleSoft system. By enrolling in COBRA and paying the monthly premium and administrative charge, coverage for benefits will continue retroactive to the date of ineligibility without a break in coverage through the period of COBRA eligibility.

WHEN CAN CHANGES BE MADE & WHEN ARE THEY EFFECTIVE?

General

If you have experienced a qualified status change event during the plan year, you may be eligible to revise certain benefit elections for the remainder of the plan year. The list of events that constitute a Qualified Status Change is provided in the "What Coverage Changes Can I Make During the Plan Year" section.

Qualified status changes must be verified and must be consistent with the event as defined under IRC Section 125. Benefit election changes are consistent with status changes only if the election changes are necessary or appropriate because of the status change.

Below are the qualified family status changes for which you may revise your current plan year elections for your medical package, dental, health care FSA and dependent care FSA. For short-term disability and life insurance, please review the last two paragraphs of this section.

Adding dependents or waiving benefits due to – birth, adoption, and placement for adoption

To add a new dependent, you must notify the EHI Department on the Group Insurance Qualified Status Change Form within 30 calendar days of the event. If you are waiving coverage for yourself and your dependents, you must complete a Group Insurance Qualified Status Change Form within 30 calendar days of the event. In all cases, you are required to provide documentation of the status change within 30 calendar days of the event date. For birth, adoption or placement for adoption or to waive benefits due to these events, the effective date of your coverage change is the event date.

In accordance with ARS 20-1057 B, if your medical coverage is under the CIGNA HMO or the OAP plan, coverage of a newborn child, a child placed for adoption or an adopted child will be effective from the date of birth or placement and will continue for the following 30 calendar days if you are the primary insured according to Coordination of Benefits National Association of Insurance Commissioners (NAIC) rules. NAIC rules determine primary responsibility for coverage based on the earliest birthday in the year of the child's parents.

There is no premium associated with coverage for the first 30 days as long as you do not enroll the child for ongoing coverage. In order for medical coverage to continue past the initial 30 days, you will be required to pay a premium retroactively to the date of the event if you are not currently in the appropriate coverage premium level (i.e., if you are paying employee-only or employee-and-spouse premium instead of employee and family or employee and child premium).

In order to properly administer the ongoing enrollment of the newborn in the medical and/or pharmacy plan, you must notify the EHI Department of your qualified status change and complete the required paperwork as specified in the preceding paragraphs. If you fail to submit your Group Insurance Qualified Status Change Form and documentation within 30 calendar days of the event, your newborn will not be covered after the initial 30 days.

Adding dependents or waiving benefits due to– all other family status change events (marriage, dependent attains or loses eligibility, court orders, legal guardianship, etc.)

Employees may revise their elections to cover newly acquired or newly eligible dependents if the request and required documentation is received by the EHI Department within 30 calendar days of the event date. The employee is required to complete a Group Insurance Qualified Status Change Form. The event date and coverage effective date will not be later than the first calendar day of the month following the date the required documents are received from the employee. The date the request is processed by the EHI Department is deemed the event date and the coverage effective date unless the event is prospective. In this case, the prospective event date is the coverage effective date. The request will be processed only when all required documentation is received by the EHI Department. The EHI Department is responsible for processing requests within 5 calendar days of receipt of all required forms and documents. Premium changes associated with your qualified status change become effective the pay period in which the new coverage is effective. If you fail to submit your form and documentation within 30 calendar days of the event, no changes will be allowed. Retroactive changes will not be allowed unless otherwise required by law.

Dropping dependents – all family status change events

When a dependent ceases to meet the definition of an eligible dependent, that dependent must be terminated from coverage. It is your responsibility to notify the EHI Department by completing a Group Insurance Qualified Status Change Form within 30 calendar days of the change. The dependent's coverage will end the last day of the pay period during which he/she lost eligibility.

If you complete the form and submit it to the EHI Department within 30 calendar days of the event date, any premium overpayment will be refunded to you and your department back to the coverage end date. If late notification is received within six months of the event, while coverage for your dependent will still end on the last day of the pay period in which the dependent became ineligible, no premium refund will be made to you until a full claims audit has been conducted to determine your liability.

Short Term Disability (STD)

If you elect STD when you first become benefit eligible or during open enrollment, you may not revise your election until the next regularly scheduled open enrollment even if you have a qualified status change. The only exceptions that may apply are if you are subject to a Reduction in Force (see HR2403) or called to active military duty.

Life insurance

If you elected additional life insurance and/or dependents life insurance, you have special rules that apply. These plans are not subject to I.R.C. Section 125. Please see the special rules that apply to these life insurance plans, in the "Life Insurance Plan" section.

WHAT COVERAGE CHANGES CAN I MAKE DURING THE PLAN YEAR?

Provided below is a list of changes to your medical and dental insurance coverage that you can make in the event you experience a status change. The coverage change must be consistent with the qualified status changes.

1. Marriage
   - Waive, if you elected coverage
   - Add newly acquired dependents to your current plan
   - Elect coverage for yourself and your dependents if you currently waive coverage
2. Divorce
   - Remove former spouse and step-child(ren) from your coverage (required)
   - Remove child(ren) from coverage, only if court order requires other coverage and verification of coverage is received by the EHI Department
   - If waived, elect coverage for yourself, and elect coverage for your dependent child(ren)
   - Waive, if elected coverage
3. Death of Spouse
   - Remove deceased spouse from your coverage (required)
   - Add dependent child(ren) who had been covered by your deceased spouse
4. Birth, Adoption, Placement for Adoption and Legal Guardianship
   - Waive, if you elected coverage
   - Add dependent child(ren) to your current plan
   - Elect coverage if you currently waive coverage
5. Spouse's Eligibility (Employment Changes, etc.)
   - Waive, if you elected coverage
   - All options if you currently waived coverage
   - Drop spouse from coverage
6. Dependent Child's Eligibility (Age, Marriage, Student Status change, etc.)
   - Add or remove dependent child(ren) to your current plan
7. Dependent Child's Eligibility (Court Orders)
   - Add or remove the dependent child to your current plan
8. Going from part-time to full-time benefit status
   - No changes allowed
9. Going from full-time to part-time benefit status
   - Can elect lower cost plan
10. Employee goes on approved LOA
    - Drop some or all benefit elections
11. Employee who drops some or all benefits at commencement of LOA and returns from LOA greater than 30 days
    - Reinstate or change benefits

WHAT IS A QUALIFIED STATUS CHANGE?

Examples of qualified status changes, as permitted by IRC Section 125, are listed below:

1. Change in status:
   a. Events that change an employee's legal marital status, including the following: marriage, death of spouse, divorce, legal separation, or annulment;
   b. Events that change an employee's number of dependents, including the following: birth, death, adoption, and placement for adoption. In the case of the dependent care spending account, a change in the age of qualifying individuals (e.g. child turns 13).

c. Any of the following events that change the employment status of the employee, the employee's spouse or the employee's dependent.

- termination or commencement of employment;
- strike or lockout;
- commencement of or return from an unpaid leave of absence (LOA) including FMLA;
- change in residence or work site where eligibility no longer exists for the plan originally selected or becomes eligible in the new residence or work site;
- change in the number of regularly scheduled hours to become benefit eligible or ineligible;
- change in job or employment status that renders the employee benefit eligible or ineligible, such as moving from temporary status (benefit ineligible) to a regular status benefit-eligible position, or changing from a contract position with no benefits to a position with benefits.

2. Dependent satisfies or ceases to satisfy eligibility requirements such as attainment of age or change in student status;
3. Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order requiring accident or health coverage for an employee's child;
4. Significant cost or coverage changes.
5. Entitlement or loss of entitlement of Medicare or Medicaid (the Arizona Health Care Cost Containment System) more commonly referred to by its acronym **AHCCCS**, the Medicaid program in Arizona.

WHAT DOCUMENTATION IS REQUIRED FOR QUALIFIED STATUS CHANGES?

The EHI Department requires documentation of your qualified status change within 30 calendar days of the event in order to process your Group Insurance Qualified Status Change Form. Notification to the EHI Department of some status changes are allowed via Employee Self Service in PeopleSoft. However, documentation must be received by the EHI Department within 30 calendar days of the change in order for the change to be accepted. Below is a list of acceptable documentation.

1. Divorce, legal separation, annulment or change in legal custody, that include a qualified medical child support order requiring accident or health coverage for an employee's child: Copy of first and last pages and any other pages relating to the order requiring coverage.
2. Change in status:
   a. Events that change an employee's legal marital status: Marriage or death certificate, divorce or other legal document or decree (first and last pages and any pages identifying the effective date of the event and the date on which the document was finalized);
   b. Events that change an employee's number of dependents: Birth certificate, court adoption documents (first and last pages and any pages identifying the effective date of the event and the date on which the document was finalized);
   c. Changes in the employment status of the employee, the employee's spouse or the employee's dependent: Copy of the document from the employer verifying the event or change of address verification such as utility bill or U.S. Postal Service change of address form.
3. Dependent satisfies or ceases to satisfy eligibility requirements: School schedule for the current semester/quarter from the institution verifying full-time student status.
4. Significant cost or coverage changes: Documentation of the before and after coverage and/or costs and the effective date of such change.

Please notify the EHI Department within the 30 calendar day period following the event if documentation is not available due to an extenuating circumstance.

HIPAA PRIVACY NOTICE

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator or sponsor of the Employee Benefit Plan, or in its roll as the health plan makes available a notice setting forth its privacy practices through the EBC/Intranet ***http://ebc.maricopa.gov/ehi*** home page. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to PHI. The privacy notice may be updated occasionally and such updates will be communicated through ***e*Nouncements***, accessible through the EBC.

SHARING OF YOUR PROTECTED HEALTH INFORMATION

You and your dependents' protected health information (PHI) will be shared with specific benefit plan representatives and others for the purposes of your health care treatment, payment for that treatment and health care operations (as defined in the HIPAA of 1996, as amended) of Maricopa County and of the benefit plan vendors, as well as for other purposes allowed or required by law. When you submit your enrollment application, make an open enrollment or qualified status change or continue with your current coverage, you are acknowledging and accepting that Maricopa County and your health care providers, which could include CIGNA, CIGNA Dental, Walgreens Health Initiatives (WHI), Magellan Health Services, Delta Dental, EDS, The Standard, Sedgwick CMS, EyeMed Vision Care, Application Software Inc. and the applicable aforementioned benefit providers in their role as plan administrators or benefit manager, may share medical and administrative information concerning you and your dependents. By participating in the benefit plan, you are releasing Maricopa County and Maricopa County's plan administrators, benefit managers and vendors from any liability for any good faith release of PHI pursuant to this acknowledgement.

EMPLOYEE CERTIFICATION

By submitting your benefit elections, you are certifying to the best of your knowledge that all information you have provided is accurate, correct and complete. You are also agreeing that you will reimburse Maricopa County for any additional premiums owed as a result of providing inaccurate, incorrect, incomplete or untimely information. You may be subject to disciplinary action, up to and including termination, for failing to provide accurate and complete information. Additionally, providing inaccurate information or failing to notify the EHI Department, will cause you to become liable and responsible for claims incurred during any period in which you or your covered dependents were ineligible.

NOTICE REGARDING USE OF YOUR SOCIAL SECURITY NUMBER

Disclosure of your Social Security Number (SSN) for purposes of enrollment and other benefit-related uses is voluntary. Identification (ID) cards from all vendors will carry either a) no ID number, b) an edited ID number (revealing only the last four digits of your SSN), c) your employee ID number, or d) a randomly system-generated number. Your SSN is transmitted to the benefit plan vendors for administrative purposes. Some vendors will use your SSN as your ID number or cross-reference their assigned ID number to your SSN. If you do not want your SSN transmitted to the benefit plan vendors, you may request an alternative ID number. If you are participating in Mariflex, the vendor must have access to your SSN to report your flexible spending account to the Internal Revenue Service (IRS). If you enroll in the group legal plan, MetLaw, the vendor requires your social security number. If you do not want your social security number sent to MetLaw, you should not enroll in this voluntary benefit.

ALTERNATIVE ID NUMBER

You may request an alternative ID number to be used in lieu of using your SSN at any time by sending your request in writing to the EHI Department. You will be provided with a form to complete before the alternative number will be assigned. This will delay your enrollment (but not your benefit beginning coverage date) in benefits until the alternative number is assigned.

The EHI Department will provide your alternative ID number to your medical, pharmacy, vision, behavioral health and dental vendors. Once the vendor assigns an alternative ID number, you and your dependents will not be identifiable by your SSN.

Assignment of an alternative ID number may become a temporary barrier to receiving medical services or to having your medical claims correctly paid. You are responsible for advising each provider that you have an alternative ID number. If the vendor uses a system-generated ID number, your alternative ID number will be cross-referenced to the system-generated ID number. When you access services, your provider will verify your current eligibility by calling the vendor. The provider must use either your current alternative ID number or your system-generated ID number so that your eligibility can be established, you can access services and your claims can be processed and paid. Additionally, when an alternative ID number is assigned, if you have ever been identified by your SSN, some vendors do not have the technology to cross-reference your records to re-establish prior authorizations or referrals for your care or to process claims submitted under your SSN because the key link between you and their records (your SSN) has been broken. This may cause a temporary delay in receipt of services or result in denied claims until you notify the vendor to correct the records.

MEDICAL PLANS

Administered by CIGNA

This section provides a brief summary of information on the different medical plans offered, how they operate and the costs of services and premium. For more detailed information, please contact the CIGNA Pre-Enrollment or customer service phone number listed in the "Who to Contact" section. Choices include CMG (CIGNA Medical Group), a managed-care health maintenance organization (HMO) plan, Open Access Plus In-Network (OAPIN), an HMO plan with open access to specialists but does not have out-of-network coverage, Open Access Plus (OAP), an HMO plan with open access to specialists and has out-of-network coverage, and a high deductible health plan, CIGNA Choice Fund, with a Health Savings Account. Some plans have a high and a low option from which to choose. High options have higher premiums but lower copayments for services while low options have lower premiums but higher copayments for services.

If you enroll in a medical plan, you must select "Tobacco User Yes" or "Tobacco User No" when completing your online enrollment through Employee Self Service. If you do not answer this question, it will be assumed that you are a tobacco user and you will be charged a higher premium. "Tobacco User" means the occasional or regular use of a tobacco product including but not limited to cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco. However, nicotine replacement products which are used to help a person stop using tobacco are not considered a tobacco product. **Tobacco user status applies to you and any of your dependents that are enrolled in a county medical plan.** Maricopa County offers a Quit Tobacco Program to assist employees with quitting tobacco. Visit the Wellness section of the EHI Web site for more information or call (602)372-7272 to enroll.

All medical plans include the following, except as noted

Alternative Medicine Benefit: Twenty self-referred alternative medicine visits per plan year are covered. Copayments vary depending upon the medical plan selected. A $60 credit for herbal/homeopathic or natural supplies dispensed in conjunction with an office visit is also covered. Providers in CIGNA's designated alternative medicine network must be used when accessing this benefit. This benefit is not available out-of-network. Covered services are:

- Physician evaluation and management
- Physical medicine
- Acupuncture/acupressure
- Massage therapy
- Homeopathic consultation
- Biofeedback/guided imagery

Behavioral Health/Substance Abuse Benefit: Provided by Magellan Health Services except for CIGNA Choice Fund for which the benefit is provided by CIGNA Behavioral Health. Refer to the "Behavioral Health and Substance Abuse" section for benefit details.

Vision Benefit: Provided by EyeMed Vision Care. See the "Vision Benefit Plan" section for benefit details.

Pharmacy Benefit: You will select your pharmacy benefit separately from your medical plan. Refer to the "Pharmacy Benefit" section for plan choices and benefit details.

24-hour worldwide emergency care.

24-hour Health Information Line[sm]: Provides access to health information from Registered Nurses at any time. When you are not sure where to go to seek non-emergency care, you can call and speak with a nurse who can respond to your health care questions, direct you to the nearest participating medical facility or provide suggestions for helpful home care that may comfort you until you can see your doctor. Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982. You also have access to the Health Information Library where you can listen to taped programs on hundreds of topics.

Wellness Programs: Well Aware for Better Health is an integrated disease management program helping CIGNA members manage asthma, low back pain, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, weight complications, and targeted conditions such as fibromyalgia, hepatitis C, irritable bowel syndrome, and more. To see if you qualify, call 800-249-6512. Once you are enrolled in a disease management program, you can contact a nurse or dietician for consultation at 877-888-3091. Healthy Babies is another wellness program for prenatal guidance, available by calling 800-244-6224.

Healthy Rewards Program: Discounts on alternative health services and health and wellness products such as fitness club memberships, chiropractic services, therapeutic massage, acupuncture, cosmetic dentistry, laser vision correction, vitamins and herbal supplements, and hearing aids and tests. Call 800-870-3470 to find out more information or go online to ***www.CIGNA.com/healthyrewards***.

myCIGNA.com: Access your benefit and claim information, request an ID card, view your provider directory, change your PCP and more through this secure online Web site.

Guesting Privileges: Provides access to in-network benefits while your dependents are temporarily absent from the service area. Call the CIGNA Customer Service Department to determine whether your dependent qualifies to participate. Certain restrictions apply.

The information on the next four pages are brief summaries of each plan. The detailed Summary Plan Documents are available on the EBC Intranet at ***ebc.maricopa.gov/ehi***.

CIGNA administers the plan. If you have questions regarding covered benefits, claims payment, the appeal process or a provider's participation status, contact CIGNA Customer Service Department, 8 AM - 6 PM MST, Monday - Friday. Additional resources that are available are CIGNA's Web sites ***www.cigna.com***, ***www.mycigna.com***, and ***www.mycignaplans.com***.

Medical claims should be mailed to:

CIGNA
P.O. Box 182223
Chattanooga, TN 37422-7223

PLAN SUMMARY CHART

Benefit Provision	CMG High:		CMG Low:		OAP In-Network:	
Type of Plan	HMO		HMO		HMO with Open Access to Specialists	
Service Area Where Care Must be Received	Maricopa County only, except for emergency care		Maricopa County only, except for emergency care		Nationally	
Residency Requirement	Must work or reside in Maricopa County		Must work or reside in Maricopa County		None	
PCP Required	Yes; CIGNA Medical Group PCP only		Yes; CIGNA Medical Group PCP only		No	
Referral Required	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		No	
Out-of-Network Coverage	No		No		No	
Network	AZ-CIGNA Medical Group Network AZ812		AZ-CIGNA Medical Group Network AZ812		National Open Access Plus AZ300	
Prior Authorization	Provider's responsibility		Provider's responsibility		Provider's responsibility	
Per Pay Period (24/yr.) Medical Premiums**	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$5.48	$89.16	$0.00	$0.00	$11.16	$90.48
Employee + Spouse	$19.98	$87.62	$15.80	$5.62	$50.90	$89.10
Employee + Child(ren)	$10.92	$89.30	$8.60	$2.40	$36.38	$90.72
Employee + Family	$34.42	$90.88	$26.86	$16.26	$75.22	$92.46

**These premiums are based on all participants being tobacco free. Medical premiums also include the behavioral health premium. Add $10 per household for tobacco-users (employees and/or covered dependents).

Find out how the plans work and compare plans to determine which plan works best for you.
Logon to www.mycignaplans.com (username: Maricopa2007 / password: cigna)

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

PLAN SUMMARY CHART

Benefit Provision	OAP High:		OAP Low:		Choice Fund-HSA[1]:	
Type of Plan	HMO with Open Access to Specialists		HMO with Open Access to Specialists		High-deductible PPO plan with partially funded Health Savings Account	
Service Area Where Care Must be Received	Nationally		Nationally		Nationally	
Residency Requirement	None		None		None	
PCP Required	No		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	Yes		Yes		Yes	
Network	National Open Access AZ300		National Open Access AZ300		National Preferred Provider Network AZ011	
Prior Authorization	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.		Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.		Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.	
Per Pay Period (24/yr.) Medical Premiums**	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$13.40	$105.96	$4.24	$71.74	$8.82	$85.40
Employee + Spouse	$58.60	$106.84	$15.80	$67.64	$24.48	$96.80
Employee + Child(ren)	$42.02	$107.68	$8.56	$70.24	$15.24	$92.32
Employee + Family	$86.72	$111.70	$26.98	$69.26	$39.60	$104.96

**These premiums are based on all participants being tobacco free. Medical premiums also include the behavioral health premium. Add $10 per household for tobacco-users (employees and/or covered dependents).

[1]Maricopa County contributes $500 for employee only and $1,000 for employee and dependent coverage to your HSA pro-rated by the number of months remaining in the plan year. You can contribute up to $2,350 (individual) or $4,650 (family) to your HSA, plus $800 catch-up if over 50. Unused balances rollover.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		CMG High Option:	CMG Low Option:	OAP In-Network:
		In-Network Coverage Only		
Deductible	Individual	None	None	None
	Family	None	None	None
Standard Percent of Co-insurance		N/A	90%	N/A
Out-of-Pocket Maximum	Individual	$1,000	$5,000	$1,000
	Family	$2,000	$10,000	$2,000
Pre-existing Condition Limitation		None	None	Yes, same as for OAP High & Low Options
Preventive Care		$15/$25	$25/$45	$20/$30
Primary Care Physician Services		$15	$25	$20
Specialty Care Physician Services		$25	$45	$30
Advanced radiology: CT, PET, MRI, MRA Scans/type of scan/day and nuclear cardiac studies		$50	$100	$100
Outpatient Lab and X-ray		$0	$0	$0
Inpatient Facility Charges*		$100/admit	$500/admit, then 10%	$200/admit
Inpatient Physician and Surgeon's Services		$0	$0	$0
Outpatient Facility Services*		$0	$250, then 10%	$100
Pre- & Postnatal Exams (after pregnancy has been determined)		$25, waived after 1st visit	$45, waived after 1st visit	$30, waived after 1st visit
Delivery		$100	$500, then 10%	$200
Urgent Care		$35, waived if admitted	$50, waived if admitted	$50, waived if admitted
Emergency Room*		$75, waived if admitted	$100, waived if admitted	$100, waived if admitted
Ambulance		$0	$0	$0
Durable Medical Equipment $3,500 maximum/yr.		$0	$0	$0
External Prosthetics		$0	$0	$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 60 visits maximum combined/yr.		$25/provider/day	$45/provider/day	$30/provider/day
Cardiac Rehab; 36 visits/yr.		$25 per visit	$45 per visit	$30 per visit
Alternative Medicine; 20 visits/yr. $60 credit for supplies/products		$15 per visit	$25 per visit	$20 per visit
Behavioral Health/Pharmacy		Magellan/WHI	Magellan/WHI	Magellan/WHI

For more detail, review the medical plan summaries on the EHI Home Page or go to ***www.mycignaplans.com*** to compare plans.

*Advanced radiology copays apply in addition to inpatient, outpatient and emergency room copays or co-insurance.

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COPAY/CO-INSURANCE COMPARISON CHART

OAP High Option:		OAP Low Option:		Choice Fund-HSA:	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
None	$500	None	$1,000	$1,200	$1,200
None	$1,000	None	$2,000	$2,400	$2,400
N/A	70% of reasonable and customary	90%	70% of reasonable & customary	90%	70% of reasonable & customary
$1,500	$3,000	$5,000	$10,000	$5,000	$5,000
$3,000	$6,000	$10,000	$20,000	$10,000	$10,000
12 months for treatment in prior 60 days. Waived with certificate of creditable coverage and for employees currently covered by a county medical plan for at least 12 months. Certificate of creditable coverage must be sent to CIGNA and also provided to the EHI Department.					
$25/$35	Covered in-network only	$35/$50	Covered in-network only	**FREE**	Covered in-network only
$25	30% after deductible	$35	30% after deductible	10% after deductible	30% after deductible
$35	30% after deductible	$50	30% after deductible	10% after deductible	30% after deductible
$100	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible; $0, no deductible if preventative	30% after deductible
$250/admit	30% after deductible	$1,000/admit, then 10%	$2,000/admit, then 30%	10% after deductible	30% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
$100	30% after deductible	$500, then 10%	$1,000/admit, then 30% after deductible	10% after deductible	30% after deductible
$35, waived after 1st visit	30% after deductible	$50, then 10%	30% after deductible	10% after deductible	30% after deductible
$250	30% after deductible	$1,000, then 10%	$2,000, then 30% after deductible	10% after deductible	30% after deductible
$50, waived if admitted	$50, waived if admitted	$75, waived if admitted	$75, waived if admitted	10% after deductible	10% after deductible
$100, waived if admitted	$100, waived if admitted	$150, waived if admitted	$150, waived if admitted	10% after deductible	10% after deductible
$0	$0	10%	10%	10% after deductible	10% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible; No limit	30% after deductible; No limit
$0	30% after deductible	10%	30% after deductible	10%	30% after deductible
$35/provider/day	30% after deductible/ provider/day	$50/provider/day	30% after deductible/ provider/day	10% after deductible/ provider/day	30% after deductible/ provider/day
$35 per visit	30% after deductible	$35 per visit	30% after deductible	10% after deductible	30% after deductible
$25 per visit	Covered in-network only	$35 per visit	Covered in-network only	$15 per visit after deductible	Covered in-network only
Magellan/WHI	Magellan/WHI	Magellan/WHI	Magellan/WHI	CIGNA Behavioral Health/CIGNA Pharmacy	

For more detail, review the medical plan summaries on the EHI Home Page or go to ***www.mycignaplans.com*** to compare plans.

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PHARMACY PLANS

Administered by Walgreens Health Initiatives

If you enroll in a medical plan, you must enroll in a pharmacy plan, except for the Choice Fund H.S.A. plan*. You have two pharmacy plans from which to choose.

Co-insurance Benefit Plan

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost* of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility and cosmetic medications, are excluded.

You will be charged the minimum or maximum copay or the co-insurance amount for the medication, based on the medication's level and cost. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the medications.

The co-insurance or the minimum or maximum copay you pay toward any covered medication apply to your out-of-pocket maximum except when a non-preferred brand name medication with a generic equivalent is purchased, the difference between the brand and the generic equivalent will not count. The out-of-pocket limit is $1,500 for an individual and $3,000 for a family**. Once the out-of-pocket limit is met, covered medications are paid 100% by the plan for the remainder of the plan year, except for the difference between the non-preferred brand and it's generic equivalent, which will continue to be your responsibility.

Consumer Choice Benefit Plan

The Consumer Choice benefit is a four-level plan in which Maricopa County fully funds the cost* of the first level (pharmacy account), you fund the cost* of the second level (employee responsibility), and you and Maricopa County share the cost* of the third level (traditional insurance) through co-insurance. Any unused portion of the pharmacy account is rolled over to the next plan year, creating a credit balance that you can use to pay for future prescriptions.

The benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility and cosmetic medications, are excluded.

The amounts you pay toward any covered medication will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is $1,500 for an individual and $3,000 for a family**. Once the out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

Co-insurance Benefit Plan & Consumer Choice Benefit Plan

THREE-MONTH SUPPLY AT CERTAIN RETAIL PHARMACIES – ADVANTAGE90™ When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at any pharmacy located in a retail pharmacy participating in Advantage90™ or through mail service, after two fills at a retail pharmacy. The physician must write your prescription for an 84-91 day supply. Refer to ***www.mywhi.com*** for a list of pharmacies participating in Advantage90™. Your cost for a three-month supply at an Advantage90™ retail pharmacy is no more than three times the one-month supply copay.

THREE-MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY Prescriptions for maintenance medications or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. You must use a specific order form when placing your first order so as to provide Walgreens Mail Service with important health, allergy and plan identification information. This form is called the Tempe Registration and Order Form and is available online at the EHI Home Page or at WHI's Web site: ***www.mywhi.com***. You can also complete registration online at the WHI Web site. Maximum copayments for the Co-insurance plan are reduced when mail service is used. Level One maximum is $28 and Level Two maximum is $70.

Note: Diabetic supplies and medications may be obtained at a CIGNA Medical Group pharmacy for $10 per item for a 30-day supply. Please show your CIGNA ID card since these costs will be charged to your medical plan instead of your pharmacy plan.
You and your covered dependents may also voluntarily enroll in a New Diabetic Management Program and may qualify for free diabetic medications and supplies. Contact the EHI Department for details or call 602-506-3758.

*Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supply.
**Family refers to employee and one or more covered dependents.

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For additional information, contact Walgreens Health Initiatives.
The Detailed Summary Plan Document is available on the EBC Intranet at ***ebc.maricopa.gov/ehi***.

Walgreens Health Initiatives

Both plans are administered by Walgreens Health Initiatives

Did you know? Diabetic medications & supplies can be free with either WHI plan with participation in a new Diabetic Management Program! Call 602-506-3758 to enroll.

Co-insurance Plan

Annual Out-of-Pocket Maximum
$1,500 Single / $3,000 Family**

	Classification	Up to 30-Day Supply		
Level 1	Generic	$2 Minimum	25% Co-insurance*	$12 Maximum***
Level 2	Preferred Brand	$5 Minimum	30% Co-insurance*	$30 Maximum***
Level 3	Non-Preferred Brand with Generic equivalent	$20 Minimum	50% Co-insurance* +	Difference between brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	$20 Minimum	50% Co-insurance*	
Level 5	Non-Preferred Brand Specialty Drugs	$50 Copay		

*** Maximums are reduced when mail service is used

Per Pay Period (24/yr.) Pharmacy Premiums	**Full-Time**	**Part-Time**
Employee	$4.98	$4.98
Employee+Spouse	$9.86	$19.18
Employee+Child(ren)	$7.40	$12.58
Employee+Family	$14.80	$24.88

Consumer Choice Plan

Annual Out-of-Pocket Maximum
$1,500 Single / $3,000 Family**

	Certain generic preventive medications are provided at no cost. List available on the EHI Home Page.				
Level 1	Pharmacy Account	Individual	$300 Individual	100% Employer paid*	Any unused amount is carried over to next plan year
		Family**	$500 Family		
Level 2	Employee Responsibility	Individual	$300 Individual	100% Employee paid*	
		Family**	$500 Family		
Level 3	Traditional Insurance Coverage			20%* covered by Employee	80%* covered by Employer
Level 4	Specialty Drug	$50 copay; does not apply to pharmacy account, employee responsibility or insurance levels; Copay applies to out-of-pocket maximum.			

Per Pay Period (24/yr.) Pharmacy Premiums	**Full-Time**	**Part-Time**
Employee	$0.00	$0.00
Employee+Spouse	$0.00	$9.32
Employee+Child(ren)	$0.00	$5.18
Employee+Family	$0.00	$10.08

*Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee.
Discount amount varies by place of service and number of days supply.
**Family refers to employee and one ore more covered dependents.

CIGNA Pharmacy Plan for Choice Fund HSA Plan

Level 1	Generic	30% after deductible
Level 2	Preferred Brand	40% after deductible
Level 3	Non-Preferred Brand	50% after deductible
Certain generic and preferred brand preventive medications are provided at no cost.		

Cost of pharmacy plan included in medical premium for Choice Fund HSA plan

The pharmacy benefit for Choice Fund H.S.A. is administered by:

CIGNA

DENTAL PLAN SUMMARY CHART

Benefit Provision	EDS		CIGNA Dental		Delta Dental	
Type of Plan	DCO (Dental Care Organization)		PPO		PPO (but does not use PPO network; see network below.)	
Service Area Where Care Must be Received	Maricopa County		Nationally		Nationally	
Residency Requirement	No		No		No	
Primary Care Dentist Required	Yes, all family members must choose the same dentist		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	No		Yes		Yes	
Network	EDS Provider Network		CIGNA Dental Network		Delta Premier Network	
Prior Authorization	No		No, predetermination recommended for services over $250		No, predetermination recommended for services over $250	
Provider Directory	***www.mydentalplan.net***		***www.cigna.com***		***www.deltadentalaz.com***	
Per Pay Period (24/yr.) Dental Premiums	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$2.08	$2.08	$6.60	$10.98	$10.82	$15.20
Employee + Spouse	$3.96	$3.96	$14.56	$25.08	$23.84	$34.36
Employee + Child(ren)	$5.18	$5.18	$15.76	$25.90	$25.80	$35.94
Employee + Family	$5.98	$5.98	$20.26	$34.22	$33.16	$47.12

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DENTAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		EDS*	CIGNA Dental		Delta Dental	
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	$0	$50		$50	
	Family	$0	$100		$100	
Annual Benefit Maximum	Standard	None	$2,000		$2,000	
	Orthodontic	None	$3,000		$3,000	
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered	5 year waiting period for replacement (major services)		5 year waiting period for replacement (major services)	
Routine Services						
Preventive Care			In-Network	Out-of-Network**	In-Network	Out-of-Network**
Routine Cleanings Sealants Space Maintainers		$0 $12/tooth $20 + lab fees	$0	20%	$0	$0
Diagnostic Exams Evaluations Consultations & X-rays		Copay $0-$20	$0	20%	$0	$0
Emergency Palliative Treatment Treatment for the relief of pain		Up to $200 reimbursement less applicable copay	$0	20%	$0	$0
Basic Services						
Restorative Fillings		Amalgam $8-$21 Resin $22-$40	Amalgam 20% Resin 50%	Amalgam 40% Resin 50%	Amalgam 20% Resin 50%	Amalgam 20% Resin 50%
Oral Surgery Extractions		From $35	20%	40%	20%	20%
Endodontics Root Canal Treatment Pulpotomy		Copay $170-$265	20%	40%	20%	20%
Periodontics Treatment of gum disease Periodontal Maintenance		Debridement: $80 Root Planing: $90	20%	40%	20%	20%
Bridge & Denture Repair		$10 + lab fees	20%	40%	20%	20%
Major Services						
Prosthodontics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		$250 + lab fees $375 + lab fees $325 + lab fees	50%		50%	
Restorative Cast Crowns & Jackets Onlays & Inlays		$250 + lab fees $135 - $170	50%		50%	
Orthodontic Services						
Orthodontic maximum is separate from annual benefit maximum		25% discount children & adults	50% children & adults		50% Adults & children age 8 + older	

*Specialist Care & treatment of TMJ are offered at a discount.

For more detail, review the dental plan documents on the EHI Home Page.

**If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount in addition to the applicable deductible and co-insurance.

HOW TO LOOK UP A PHYSICIAN OR DENTIST ONLINE

CIGNA Medical and Dental Plans – Start at www.cigna.com

1. From the home page, select the Provider Directory link
2. For medical, enter your physician search information
   For dental, select the radio button next to Dentist and enter the search information
3. Click on the "Next" button
4. Continue with the applicable instructions below

CMG High and Low Options *use the AZ – CIGNA Medical Group Network AZ812*

(Paper Directory titled "The Many Faces of CIGNA Medical Group")

1. On the next page, under "What type of plan you have" section, choose "Network (HMO) Plans or Point of Service (POS) Plans"
2. From the "Network (HMO) Plans or Point of Service (POS) Plans" drop-down list, select AZ-CIGNA Medial Group
3. Under "What you're looking for" section, select "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list
4. Click on the "Search" button to view the provider search response

OAP In-Network and OAP High and Low Options *use the National Open Access Plus Network AZ300*

(Paper Directory titled Open Access Plus/Open Access Plus In-Network)

1. On the next page, under the "What type of plan you have" section, choose "Open Access Plus Only"
2. Under "What you're looking for" section, select "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list
3. Click on the "Search" button to view the provider search response

Choice Fund Health Savings Account (HSA) *use the National Preferred Provider Network AZ011*

(Paper Directory titled "Preferred Provider Network")

1. On the next page, under "What type of plan you have" section, choose "Preferred Provider Organizations (PPO)"
2. Under "What you're looking for" section, select a physician listed under the "Specialist" area and the type from the corresponding drop-down list
3. Click on the "Search" button to view the provider search response

CIGNA Dental

On the next page, under "What type of plan you have" section, choose "Managed care plan with open access to dentists for CIGNA Dental PPO" and the type from the drop-down list. Click on the "Search" button to view the dental search response.

Other Dental Plans

EDS

1. Start at ***www.mydentalplan.net***
2. From the Home page, under the Members Tool section, click on the "Dentist Search" link
3. You can search by city, dentist's last name or download a provider directory

Delta Dental

1. Start at ***www.deltadentalaz.com***
2. Click on Dentist and then Dentist Search
3. When a new page appears, under "1. Product Selection", select "Dental Premier" and continue entering the identifying information
4. Or call 602-938-3131 and select 3 and enter the zip code to hear a listing of dentists in your area

VISION PLAN

Administered by EyeMed Vision Care

If you enroll in a County medical plan, you must enroll (cannot waive) in the vision benefit. The County also offers this plan as a separate (stand-alone) vision plan for employees who choose to waive their medical benefits and wish to enroll in the vision plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	$35
Exam Options:		
Standard Contact Lens Fit and Follow-Up*	Up to $55	N/A
Premium Contact Lens Fit and Follow-Up**	10% off retail price	N/A
Frames:		
Any available frame at provider location	$130 allowance, 20% off balance over $130	$50
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lenticular	$10 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$0	$25
Standard Anti-Reflective Coating	$45	N/A
Standard Progressive (Add-on to Bifocal)	$65	N/A
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$130
Disposable	$0 Copay, $130 allowance, plus balance over $130	$130
Medically Necessary	$0 Copay, Paid-in-Full	$250
Laser Vision Correction	$150 allowance; once per lifetime per eye	
Frequency:		
Examination	Once every 12 months	
Frame	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

**Premium Contact Lens Fitting - all lens designs, materials and speciality fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

Additional Discounts:

Member will receive a 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision.

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at ***www.eyemedvisioncare.com***. The contact lens benefit allowance is not applicable to this service.

Per Pay Period (24/yr.) Vision Premiums w/Medical Plan	**Full-time**	**Part-time**
Employee	$0.00	$0.00
Employee + Spouse	$0.44	$1.30
Employee + Child	$0.30	$1.32
Employee - Family	$0.96	$1.48

Per Pay Period (24/yr.) Vision Premiums w/o Medical Plan	**Full & Part-time**
Employee	$4.84
Employee + Spouse	$9.12
Employee + Child	$9.56
Employee - Family	$14.04

BEHAVIORAL HEALTH PLAN & EMPLOYEE ASSISTANCE PROGRAM

Administered by Magellan Health Services

Maricopa County offers both an Employee Assistance Program (EAP) and Behavioral Health Benefit administered by the same company, Magellan Health Services (Magellan). All employees (including contract and temporary) and their dependents are eligible for the EAP Program. Dependents under EAP are defined differently than under your health and dental plans. EAP is available for anyone living in your household and for children going to school out of state or who live out-of-state if you are responsible for benefits. However, the Behavioral Health benefit if limited to those employees who have elected CIGNA medical coverage (except for CIGNA Choice Fund Health Savings Account that has coverage through CIGNA Behavioral Health) and to their dependents that are covered under the Medical Plan. For details about the EAP and behavioral health benefit, you may refer to the Magellan brochure and Behavioral Health Summary Plan Document located on the EBC/Intranet at ***http://ebc.maricopa.gov/ehi*** or on the Internet Web site at ***www.maricopa.gov/benefits***. In addition to EAP and behavioral health services administered by Magellan, Sheriff's Office employees and their dependents may access the Sheriff's Office Behavioral Health Services Unit by calling 602-876-1852.

EAP Program

The Employee Assistance Program (EAP) offered through Magellan is an employer-paid benefit that provides short-term counseling for both personal and work-related issues for you and your dependents. There is no premium charged to you for this benefit and there is no copayment when you use this service.

Sometimes employees face problems that they cannot solve. Concerns can become overwhelming and affect work performance, personal happiness, family relations and health. When this occurs, professional help may be needed to resolve the problem before it becomes a larger issue. You will be assisted by a behavioral health professional who will ensure that your treatment is provided at the most appropriate level for your situation.

Your EAP provides a full range of counseling and referral services for individual, family and marital concerns, stress and job-related matters, child and domestic abuse, chemical and alcohol dependency assessment, and legal or financial issues. Counseling is available by phone or in person, depending on your preference.

Counseling

Your EAP benefit provides up to eight individual counseling sessions for you and your dependents per person, per problem, per year. If sufficient need is shown, upon your approval, your counselor may encourage other member of your family to participate. Magellan provides the strictest confidentiality possible, as set forth in state and federal statutes. Release of information by the EAP concerning an individual can be given only with your written consent, except where required by law (e.g., when child abuse is suspected or when posing a danger to self or others).

Legal Consultation

Your EAP provides legal consultation services. You can call to be referred to an attorney for a prepaid initial in-person consultation or for an immediate telephonic consultation on issues such as estate planning, family and divorce law, civil and criminal matters, and more.

Financial Counseling

Your EAP also includes services to help you reach your financial goals. When you call, you'll be put in touch with a financial expert who can provide information and answer questions on a wide range of topics, including planning for retirement, debt consolidation, and more.

For more information regarding the EAP benefit or to make an appointment, contact Magellan at 888-213-5125, 24 hours a day, seven days a week or online at ***www.magellanhealth.com***.

Behavioral Health Benefit

The behavioral health benefit provides services that support your well-being. These services help you deal with a wide range of issues, including:

Depression	Legal concerns	Anger management
Severe stress and anxiety	Eating disorders	Financial worries
Alcohol or drug dependency	Grief and loss	Compulsive gambling

Through these services you can receive confidential counseling whenever you and/or your eligible dependents are faced with a personal challenge. Protecting your confidentiality is Magellan's top priority. All records, including personal information, referrals and evaluations, are kept confidential in accordance with federal and state laws.

The adjacent table is a summary of your benefits. It is important for you to understand that in-network benefits received through a participating provider are payable only if each service is determined to be medically necessary and is approved by Magellan before you start treatment. Higher levels of care for out-of-network providers (such as inpatient, residential, intensive outpatient, and partial hospitalization) also require prior approval by Magellan Health Services. However, out-of-network outpatient individual or group counseling services do not require prior approval.

For more information regarding the Magellan behavioral health and substance abuse benefit, claims payment, to obtain prior authorization or to find a participating provider, contact Magellan, 24 hours a day, seven days a week at 888-213-5125.

Magellan processes behavioral health claims, which should be mailed to: Magellan
P.O. Box 1098
Maryland Heights, MO 63043.

Behavioral Health Benefits

Level of Care	In-Network Benefit	In-Network Rules	Out-of-Network Benefit	Out-of-Network Rules
Inpatient Hospitalization	30 days per year are shared between in and out-of-network benefits $25 co-pay per day	Preauthorization required	30 days per year are shared between in and out-of-network benefits $500 deductible Plan pays $250 per day after deductible is met. All other costs after plan payment of $250 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain pre-authorization results in no reimbursement
Partial Hospitalization	Benefit is derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial day per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day $20 co-pay per day	Preauthorization required	Benefit derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial days per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day $250 deductible Plan pays $125 per day after deductible. All costs after plan payment of $125 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
Residential	60 days per year $12.50 co-pay per day	Preauthorization required	No benefit	N/A
Intensive Outpatient (IOP)	45 IOP visits per year are shared between in and out-of-network benefits $100 co-pay per program	Preauthorization required $100/program co-pay applies to a continuous episode of care in IOP. If patient discontinues & restarts program, a new $100 co-pay is applied	45 IOP visits per year are shared between in and out-of-network benefits Plan pays $40 per visit. All other costs after plan payment of $40 per visit are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
Outpatient therapy (individual, family, and medication evaluation)	30 visits per year are shared between in and out-of-network benefits $10 co-pay per visit	Preauthorization required	30 visits per year are shared between in and out-of-network benefits Plan pays $25 per visit. All other costs after plan payment of $25 per visit are member's responsibility	No preauthorization
Outpatient Group Psychotherapy	60 visits per year are shared between in and out-of-network benefits $5 co-pay per visit	Preauthorization required	60 visits per year are shared between in and out-of-network benefits Plan pays $15 per visit. All other costs after plan payment of $15 per visit are member's responsibility	No preauthorization
Ongoing Medication Management	$10 co-pay per visit Not subject to Outpatient visit limits	Preauthorization required	Plan pays $25 per visit. All other costs after plan payment of $25 per visit are member's responsibility Not subject to Outpatient visit limits	No preauthorization
Lifetime Maximums	No lifetime maximum		$5 million lifetime maximum	

The premium for the behavioral health benefit health benefit is included in the medical premium.

Behavioral Health Benefits for CIGNA Choice Fund H.S.A. Plan

Mental Health and Substance Abuse	In-network	Out-of-network
Inpatient	90% after plan deductible; 60 days combined maximum per plan year	70% after plan deductible; 60 days combined maximum per plan year
Outpatient	90% after plan deductible; 20 visits combined maximum per plan year	70% after plan deductible; 60 days combined maximum per plan year
Outpatient Group Therapy Mental Health (MH) *(One gourp therapy session equals one individual therapy session)*	90% after plan deductible	Subject to the same co-insurance and medical plan deductible as Outpatient MH visits
Intensive Outpatient Mental Health *Maximum: Up to 3 programs per plan year based on ratio of 1:1 with outpatient MH visits*	50% after plan deductible	50% after plan deductible

The premium for the behavioral health benefit health benefit is included in the medical premium.

LIFE INSURANCE PLAN

Fully Insured by The Standard

Your basic and additional life insurance, basic and voluntary accidental death and dismemberment insurance, and dependents life insurance benefits are provided through Standard Insurance Company ("The Standard"). Evidence of insurability may be required when you make your election for additional life insurance depending on the level requested and the total value of your basic and additional life insurance. Evidence of insurability may also be required for late application for additional life insurance. Once you purchase additional life or dependents life insurance, you can reduce it or cancel it at any time.

Basic Term Life with Basic Accidental Death & Dismemberment (AD&D) Insurance

The County provides you with, and pays 100% for, a basic term life insurance benefit equal to your annual salary (excluding overtime, bonus or commissions) rounded up to the next highest $1,000 to a maximum of $500,000. Coverage begins on the day after you complete your eligibility waiting period, if a waiting period applies. Life benefits are paid for any cause of death. In addition to the death benefit, AD&D benefits up to the amount of basic life coverage may be payable if an accident is the cause of death or if a dismemberment occurs. Evidence of insurability is not required for basic life and basic AD&D coverage.

Additional Life and Voluntary Accidental Death & Dismemberment (AD&D) Insurance

If you want to add to your basic level of coverage, you can apply for additional life and voluntary AD&D insurance. You pay all of the premium for additional life and voluntary AD&D insurance. Evidence of insurability is required for additional life when the coverage requested is greater than the guarantee issue amount of $500,000.

The amount of your life insurance coverage may not exceed $1 million of basic life and additional life combined. The amount of your AD&D insurance coverage may not exceed $500,000 of basic AD&D and $500,000 of voluntary AD&D.

If you purchase additional life insurance at the time you are a new hire, you can elect coverage in amounts of 1, 2, 3, 4 or 5 times your annual salary. Evidence of insurability will be required for an amount greater than $500,000. If you elect more than $500,000, you will be enrolled for coverage up to $500,000 until your evidence of insurability application for the amount in excess of $500,000 has been approved.

If you didn't enroll in additional life insurance as a new hire, you may apply for any level of coverage (1, 2, 3, 4 or 5 times your annual salary) at any time with satisfactory evidence of insurability.

If you experience a qualified status change, you can, within 30 calendar days of that change, add or increase additional life coverage (1, 2, 3, 4 or 5 times your annual salary) without completing an evidence of insurability form, unless the requested amount is greater than $500,000. If you apply for any amount of life insurance over $500,000 and you complete an evidence of insurability form, if you are not approved for the increase in coverage, you will remain at the same level you had prior to applying for the increase. However, if your current level is less than $500,000, your coverage will be increased to the next level as long as that level does not exceed $500,000. To learn what constitutes a qualified status change, refer to "What is a Qualified Status Change?" section.

During an annual enrollment period, you can increase your additional life coverage by one level without completing an Evidence of Insurability application, provided the increased amount does not exceed $500,000. If you wish to increase your coverage by more than one level or if the increased amount is over $500,000, you must complete an Evidence of Insurability application. If you do not complete the Evidence of Insurability application or if you are not approved for the increase in your coverage, you will remain at the same level you had prior to applying for the increase. However, if your current level is below the guarantee issue amount of $500,000, your coverage will be increased to the next level.

Evidence of Insurability

Evidence of insurability is required for a member or dependent when:

- electing an amount in excess of the guaranteed issue limit; and
- increasing coverage beyond the amount allowed during open enrollment and qualified status change
- benefits are reinstated
- applying more than 30 calendar days after you become eligible (late entrant)
- increasing dependents life insurance

Evidence of insurability is not required for voluntary AD&D insurance. The Evidence of Insurability (Medical History Statement) application is available at ***www.standard.com/mybenefits/maricopa***.

For all employees who are required to complete an Evidence of Insurability (Medical History Statement) application, The Standard will review the information and make a determination whether to approve or deny your request for additional coverage. The Standard may request further information, including, but not limited to, medical records, when making a determination. Coverage and the associated premium do not become effective until The Standard approves your request. For new hires, the effective date of coverage

is the first day of the pay period next following the date your application is approved. Approved increases are effective the first day of the calendar month next following the date your application is approved, or the following July 1 if you apply during an annual enrollment period.

Life Features

- Repatriation
  - Available when death occurs more than 75 miles from insured's primary residence
  - Reimburses the lesser of 2% of life benefit (Basic and Additional) or $2,500, for transportation of an insured's remains to a mortuary near the primary residence
- Accelerated Benefit
  - Applies to insured who is terminally ill with 12 or less months to live
  - Limited to 50% of Basic and Additional life
- Assignment
  - Benefits are not assignable

Medex® Travel Assist Benefit - Group# 7088

Medex® is a comprehensive program of information, referral, assistance, transportation and evacuation services when eligible members are traveling more than 100 miles from home or in a foreign country. The Medex brochure, which contains the ID card, is posted on the EHI Web site and on the Standard's Web site.

- Services
  - Pre-Trip assistance
  - Medical assistance
  - Emergency transportation services
  - Travel assistance
  - Personal security
  - Medical supplies
- Eligibility
  - Any Maricopa County employee covered by The Standard's Group Life insurance plan and his/her eligible dependents (spouse and/or unmarried dependent children under age 19 or through age 24 if a full-time student)

Special Rate for Non-Tobacco Users

As part of the County's commitment to good health, a reward is offered for leading a healthier lifestyle. If you are not a tobacco user, your life insurance premiums are lower than those of an employee who uses tobacco.

Note: Misstatement of tobacco use status may result in the life insurance company resinding coverage

5 Year Age Categories *(Age on last January 1)*	**Employee Cost Monthly per $1,000 of Coverage** *(Non-Tobacco Multiplier)*	**Employee Cost Monthly per $1,000 of Coverage** *(Tobacco Multiplier)*
Under 25	$0.040	$0.065
25-29	$0.047	$0.070
30-34	$0.062	$0.080
35-39	$0.070	$0.136
40-44	$0.092	$0.194
45-49	$0.150	$0.385
50-54	$0.230	$0.709
55-59	$0.390	$0.722
60-64	$0.660	$1.120
65-69	$0.950	$1.370
70 and older	$1.760	$2.250

Additional Life Insurance Premium Calculator Example

If you are enrolling online through Employee Self Service, the system calculates your premium automatically.

Take your annual base salary - **example: $24,500**					
Round up to the nearest $1,000	$25,000	$25,000	$25,000	$25,000	$25,000
Multiply	1x Salary	2x Salary	3x Salary	4x Salary	5x Salary
Salary amount	$25,000	$50,000	$75,000	$100,000	$125,000
÷ divided by $1,000	**25**	**50**	**75**	**100**	**125**

Refer to the Additional Life Insurance table above to find your age category and multiplier

Multiply the divided result from the last calculation in the table above by the multiplier and divide by 2 to calculate the per pay period premium (24/yr.)

Example: Age 37	**Multiplier for Non-Tobacco User $0.070**	**Multiplier for Tobacco User $0.136**	**Coverage Amount**
1 x Salary	$0.070 x 25 = $1.75/2 = **$0.88**	$0.136 x 25 = $3.40/2 = **$1.70**	$25,000
2 x Salary	$0.070 x 50 = $3.50/2 = **$1.75**	$0.136 x 50 = $6.80/2 = **$3.40**	$50,000
3 x Salary	$0.070 x 75 = $5.25/2 = **$2.63**	$0.136 x 75 = $10.20/2 = **$5.10**	$75,000
4 x Salary	$0.070 x 100 = $7.00/2 = **$3.50**	$0.136 x 100 = $13.60/2 = **$6.80**	$100,000
5 x Salary	$0.070 x 125 = $8.75/2 = **$4.38**	$0.136 x 125 = $17.00/2 = **$8.50**	$125,000

Voluntary AD&D Benefits

This plan also includes voluntary AD&D insurance from The Standard. With voluntary AD&D insurance, you or your beneficiaries may be eligible to receive an additional amount in the event of death or dismemberment as a result of an accident.

Eligible employees may choose voluntary AD&D coverage of 1, 2, 3, 4 or 5 times their annual salary, rounded to the next $1,000. The maximum amount is $500,000.

You may elect voluntary AD&D coverage for yourself, or you may elect family coverage for you and your spouse and child(ren). If you elect family coverage, the amount of AD&D coverage for your spouse and child(ren) will equal a percentage of your voluntary AD&D insurance as follows:

- Spouse only: 60%
- Child(ren) only: 10% for each child, not to exceed $25,000
- Spouse and child(ren): 50% for your spouse; 5% for each child

You are not required to elect additional life coverage in order to elect voluntary AD&D.

Voluntary Accidental Death & Dismemberment Family Monthly Cost
$0.035 per $1,000
Employee Only Cost
$0.02 per $1,000

Other voluntary AD&D benefit features are listed below:

- Seat Belt
  - Lesser of $25,000 or 10% of AD&D benefit payable for loss of life
    - Applies to insured passenger or driver as evidenced by police report
- Airbag
  - Lesser of $15,000 or 5% of the AD&D benefit payable for loss of life
    - Applies if seat belt benefit is payable for a passenger or driver in position to be protected by airbag as evidenced by police report
- Career Adjustment
  - Lesser of $10,000 or 25% of AD&D benefit; $5,000 per year maximum
    - Payable to surviving spouse
    - Pays tuition expense up to three years after death
- Child Care
  - 3% of the amount of the AD&D benefit; $2,000 per year maximum
    - Payable to surviving spouse for eligible child(ren)
    - Pays child care expenses (for a licensed provider) up to three years after death

- Higher Education
  - Lesser of $40,000 or 25% of AD&D benefit; $10,000 per year maximum
    - Available to surviving child(ren) at or near high school/college age
    - Pays tuition expense up to four years after member's death
- Line of Duty
  - Lesser of $50,000 or 100% of the amount of AD&D benefits payable for the loss of insured public safety officer (does not include corrections, probation, parole or judicial officers)
- Occupational Assault
  - Lesser of $25,000 or 100% of the amount of AD&D benefit payable for the loss if assaulted while actively at work as evidenced by police report
- Public Transportation
  - Lesser of $200,000 or 100% AD&D benefit payable for loss by a fare paying passenger on public transportation

AD&D Exclusions

AD&D benefits are not payable for death or dismemberment caused by or contributed by:

- War or acts of war
- Suicide or other intentionally self-inflicted injury
- Injuries sustained while committing or attempting to commit a felony
- Any drug not used in accordance to the directions of a physician
- Sickness, pregnancy, heart attack or stroke
- Medical or surgical treatment for any of the above

Dependents Child and Spouse Life Coverage

In addition to basic and additional life insurance for yourself, you may choose dependents life insurance for your eligible dependents. Note: You may not cover your spouse as a dependent if he or she is enrolled for basic life coverage as a Maricopa County employee.

Child Life

Child Life coverage may be purchased for the employee's dependent child(ren) from live birth to age 19, or to age 25 if a full-time student. Coverage may also be purchased for a continuously disabled child(ren). You must provide proof of disability to The Standard within 30 days after a) the date insurance would otherwise end because of the child's age or b) the effective date of Maricopa County's coverage under Standard's policy, if you child is disabled on that date. Contact the EHI Department to obtain the appropiate form to complete for a disabled child.

Coverage is available initially in increments of $5,000, from $5,000 to a maximum of $20,000. The child coverage amount may not exceed the total amount of the employee's life insurance (Basic and Additional combined). Evidence of insurability is required for child coverage amounts greater than $10,000. Once insured, all increases require evidence of insurability.

Children (live birth to 25 years if full-time student)	
Monthly Cost	Coverage Amount
$0.50	$5,000
$1.00	$10,000
$1.50	$15,000
$2.00	$20,000

Spouse Life

Spouse Life coverage may be purchased for the employee's legal spouse initially in increments of $10,000, from $10,000 to a maximum of $100,000. The spouse coverage amount may not exceed the total amount of the employee's life insurance (Basic and Additional combined). Evidence of insurability is required for spouse coverage amounts greater than $50,000. Once insured, all increases require evidence of insurability.

The premium for Spouse Life Insurance coverage is based on the age of the spouse as of January 1 of the current year. In order for the premium to calculate accurately you must ensure that your spouse's age is included on the dependent record.

Spouse Life - Monthly Cost	
Age on last January 1	**Spouse**
Under 25	$0.06/$1,000
25-29	$0.07/$1,000
30-34	$0.08/$1,000
35-39	$0.10/$1,000
40-44	$0.12/$1,000
45-49	$0.20/$1,000
50-54	$0.34/$1,000
55-59	$0.54/$1,000
60-64	$0.90/$1,000
65-69	$1.28/$1,000
70 and older	$2.08/$1,000

Claims Process

Claims must be filed no later than one year from the date of loss. A certified death certificate is required when filing a claim. Please contact the EHI Department in the event of a loss of life or an accidental dismemberment. The Benefits Specialist will assist with providing the Beneficiary Statement Form to the beneficiary and completing the Proof of Death Form.

Summary of Coverage

Coverage	Who is Covered?	Minimum	Maximum	Evidence of Insurability	Who pays premium?	Monthly Premium
Basic Life	Employee Only	1 x salary	$500,000	None	Maricopa County	.10/1,000
Basic AD&D	Employee Only	1 x salary	$500,000 (matches Basic Life amount)	None	Maricopa County	.02/1,000
Additional Life[2]	Employee Only	1 x salary	5 x salary to a combined total of $1M (Basic + Additional) at new hire or status change. May only increase 1 level during OE.	>$500,000	Employee	Based on smoker status & age
Spouse Dependent Life	Legal Spouse of Employee	$10,000	$100,000 but not more than EE's combined Basic + Additional. Once insured, all increases require EOI.	>$50,000 for initial enrollment. Once insured, all increases require EOI, even at OE.	Employee	Based on age
Child(ren) Dependent Life	Child(ren)	$5,000	$20,000 per child, but not more than EE's combined Basic + Additional per child. Once insured, all increases will require EOI.	>$10,000 for initial enrollment. Once insured, all increases require EOI, even at OE.	Employee	.10/1,000
Employee Only Voluntary AD&D[1]	Employee Only	1 x salary	5 x salary to a maximum of $500,000	Does not apply to AD&D	Employee	.02/1,000
Family Voluntary AD&D[3]	Employee, Spouse and Child(ren)	1 x salary	5 x salary to a maximum of $500,000	Does not apply to AD&D	Employee	.035/1,000

[1]Evidence of Insurability is always required for a late entrant (other than a status change or Open enrollment)

[2]Employee does not have to enroll in Additional Life in order to purchase Voluntary AD&D

[3]Family coverage includes employee and/or legal Spouse and/or Child(ren). Employee may not be insured for Employee Only Voluntary AD&D coverage and Family Voluntary AD&D coverage. Family coverage amounts are a) 60% of employee's voluntary AD&D amount when only a Spouse is covered; b) 10% of employee's voluntary AD&D amount up to $25,000 maximum when only a Child(ren) is covered; and c) 50% of employee's voluntary AD&D amount for a Spouse and 5% for each Child when both Spouse and Child(ren) are covered.

Portability

If your group coverage ends due to employment termination, retirement or reduction in hours, you may be eligible for portable group basic, additional, AD&D and dependent coverages. The portable insurance is available for up to your current coverage amount up to $1,000,000 or you may decrease the amount of your coverage.

To apply, you must complete the Group Life Insurance Portability form and send it to The Standard along with premium payment within 45 calendar days after your group insurance coverage ends. You and the EHI Department must complete portions of this form. The form is available on The Standard's Web site.

If you die or become divorced, your dependents may be eligible for portable group insurance coverage. The maximum amount of dependents life insurance that may be continued is the lesser of the amount in effect on the day before the insurance would otherwise end or $100,000 for your spouse and $10,000 for your child. Your spouse must continue insurance in order to continue insurance for a child.

If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage.

Conversion

When your group life insurance terminates due to termination of benefits while on a leave of absence (see bullets below), you can convert your basic and additional life coverage (not AD&D) to an individual whole life policy or you may purchase one year term insurance. If you purchase the term insurance, your policy will automatically be renewed at your attained age as a whole life policy at the end of the year, provided the premium is paid on the anniversary. Conversion applies at the end of the following periods.

- If you are not working due to injury or sickness, you can continue to be covered through the end of the pay period following 180 days from the date your approved, unpaid leave status began.
- If you are on a military leave of absence, you will be covered through the end of the pay period following 90 days from the date your military leave of absence began.
- If you are on an approved personal leave of absence, you will be covered through the end of the pay period following 90 days from the date your leave of absence began.

To apply for conversion, you must complete the Application for Conversion of Group Insurance and send it along with premium payment to The Standard within 45 calendar days after your group insurance coverage ends. You and the EHI Department must complete portions of the form. The form is available on the Standard's Web site.

Beneficiaries

You should name a beneficiary for your basic and additional life insurance benefits when you become insured. You may name primary and secondary beneficiaries, and you may name more than one beneficiary as primary and more than one beneficiary as secondary. You may allocate benefits by percentage or amount.

The Beneficiary Designation form is located on the EBC Intranet ***http://ebc.maricopa.gov/ehi/*** under the Forms link.

If you allocate your benefit as a percentage, you must use a whole percentage. Primary beneficiary designations must equal 100%. Secondary beneficiary designations also must equal 100%.

If you allocate your benefits as an amount, you also must use whole numbers and you must designate a beneficiary to receive any remaining amount.

You may change your beneficiary at any time. The new beneficiary designation will be effective as of the date you submit an electronic designation during annual enrollment or make a beneficiary change online through Employee Self Service.

This is a brief summary of the life and accidental death and dismemberment insurance coverages. For further details of the coverages, you may refer to Maricopa County's Group Life Insurance Certificate on The Standard's Web site.

For more information regarding the life insurance policy or claims payment, contact The Standard Insurance Company at 888-414-0396 or online at ***www.standard.com/mybenefits/maricopa***.

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This information is only a brief description of the group Basic Life/AD&D, Additional Life/AD&D insurance policy. For more complete details of coverage, go to The Standard's Web site or contact The Standard.

SHORT-TERM DISABILITY PLAN

Administered by Sedgwick CMS

Short-term disability (STD) is a plan that replaces a portion of your monthly salary while you are disabled. There is a 3-week waiting period from the onset of your disability during which time you are required to use FML/sick. If you do not have enough of this time, you must use PTO/vacation time. If you have more than 3 weeks FML/sick leave, it all must be exhausted before benefits begin. The maximum payment period is 23 weeks. Any FML/sick leave that continues past the 3-week waiting period reduces the 23-week payment period.

What benefit coverage amount can you elect?

You elect the benefit coverage amount when you enroll for STD coverage. You may elect 40%, 50%, 60% or 70% of your monthly salary. The maximum benefit is $1,000 per week.

Note: If your weekly disability payment will be at the $1,000 per week maximum, you may be enrolling in a coverage level with a higher multiplier than necessary. Refer to the STD calculator on the Benefits home page to determine the most cost-effective coverage level.

You may only increase or decrease your coverage during Open Enrollment. No changes will be allowed during the plan year (July 1 through June 30) except when ineligible for benefits (i.e., during Career Center following a reduction in force or when called to active military duty).

This plan contains a pre-existing condition if you have a condition related to your disability for which you received treatment 90 days before your coverage became effective. In this case, benefits will not be payable for that condition until you have been treatment free for 3 months or covered by the plan for 12 months.

Changes resulting in an increase in benefits are subject to the pre-existing condition. Example: If you previously elected a 50% benefit and during an Open Enrollment period changed your election to a 70% benefit, the difference between the 50% and the 70% benefit is subject to pre-existing condition payment criteria.

If your claim is related to a mental health diagnosis, Sedgwick CMS will work with Magellan Health Services to ensure that you receive a disability assessment and care by a licensed mental health professional and that you are assigned a care coordinator who will regularly work with you, Sedgwick CMS and your mental health provider on your treatment plan and your return-to-work goals. The STD benefit includes a return-to-work incentive designed to lessen the financial hardship that your disability caused by allowing you to return to work on a part-time basis within your restrictions and limitations. Your STD benefit continues to be paid, within certain limits, in addition to your part-time earnings. Refer to the STD Summary Plan Document for an example of this calculation.

How is your benefit payment calculated?

To calculate the amount of your weekly benefit, multiply your weekly earnings by the percentage of the benefit coverage amount you elected and deduct any other income you are receiving that offsets your benefit.

Benefits payable for less than one weekly period will be paid to you at the rate of one-seventh of the STD benefit amount for each day of disability. Other income may offset your disability payment.

Short-Term Disability Rate Calculation Example

Coverage	Multiplier
40%	0.35%
50%	0.55%
60%	0.85%
70%	1.32%

Annual Salary:	**$25,000**
Annual Salary divided by 12 months = Monthly Salary	**$25,000 ÷ 12 = $2,083.33**

Monthly Salary: $2,083.33	40% Option	50% Option	60% Option	70% Option
Monthly Premium = Monthly Salary (up to Maximum Monthly Salary) multiplied by Rate Multiplier	$2,083.33 x 0.0035	$2,083.33 x 0.0055	$2,083.33 x 0.0085	$2,083.33 x 0.0132
Monthly Premium	$7.29	$11.46	$17.71	$27.50
Pay Period Premium = Monthly Premium divided by 2	$3.65	$5.73	$8.86	$13.75

Refer to the Short-Term Disability Summary Plan Document on the EHI Web site for further details.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MARIFLEX FLEXIBLE SPENDING ACCOUNTS

Administered by ASI

Maricopa County offers two flexible spending accounts (FSA) that allow you to pay for health care and/or day care expenses for your dependents with tax-free money. Once you enroll in an FSA, you must re-enroll during each Open Enrollment to renew your spending account(s).

When you elect to participate in an FSA, your gross income is reduced because your FSA contributions are not subject to Medicare, OASDI, federal or state income taxes. The amount of your contribution is called your annual pledge which is divided by the number of pay periods remaining in the plan year. Eligible health care expenses must be incurred during the plan year (July 1 through June 30) or the following 2½ month grace period (the following July 1 through September 15). Claims for reimbursement for the health care and/or the dependent care FSAs must be submitted by the following November 30. To file a claim, complete the claim form located on the EHI Web site under the "Other" tab or the ASI Web site.

Health Care FSA

You can enroll in the health care FSA (unless you enroll in the Choice Fund HSA medical plan or are covered by an HSA) to pay for eligible health care expenses that are not covered by your insurance such as office visit or prescription copays. Certain over-the-counter products purchased to treat an existing or imminent medical condition may qualify as a covered medical expense. These over-the-counter items include allergy medications, smoking cessation products, aspirin, and cold medications. Eligible expenses are defined by the Internal Revenue Service and can be found in IRS Publication 502.

You can set aside up to $5,200 as your plan year contribution.

An optional debit card, for use at the pharmacy, is available for a small monthly payroll deduction. The debit card will allow you to process your claim at the time you receive your prescription, at most pharmacies.

Because the Walgreens Health Initiatives pharmacy plans require you to purchase maintenance medication in 90-day quantities, it can be very beneficial for you to consider opening an FSA since your plan year contribution is available as of July 1.

Limited Use FSA

If you enroll in the CIGNA Choice Fund HSA medical plan, you can still take advantage of the Mariflex plan. However, you and your covered dependents can only participate in the Limited Use plan. You can set aside up to $5,200 as your plan year contribution. This plan allows you to be reimbursed for dental and vision care services (as defined by the IRS) that are not covered by your insurance. The Mariflex Debit card is not available for use with the Limited Use FSA.

Dependent Day Care FSA

Dependent care Flexible spending accounts allow you to use pre-tax money to pay for dependent daycare for your dependents under 13 or your spouse or dependent who is physically or mentally incapable of self-care which gives you and your spouse the ability to work. Refer to IRS publication 503 for more information.

You can set aside up to $5,000 as your calendar year maximum contribution.

To find out more about the Mariflex FSAs including what items are eligible for reimbursement, contact ASI, the Mariflex Flexible Spending Account Administrator by phone or via email with your specific questions.

Don't let him take YOUR MONEY!

DEFERRED COMPENSATION

Administered by Nationwide Retirement Solutions

To enhance your future, Maricopa County, in partnership with Nationwide Retirement Solutions (NRS), offers you a deferred compensation plan.

Your pension plan through ASRS or PSPRS was not designed to provide your entire retirement income, which is why participating in a deferred compensation program is an essential step to achieving financial independence upon retirement. A deferred compensation program allows you to contribute money, before it is taxed, to an account. When you withdraw the monies from your deferred compensation account, typically during retirement, you will have to pay the applicable taxes. However, tax is paid only on the amounts you withdraw in a given year. Meanwhile, the rest of your investment has the opportunity to continue to grow tax deferred.

Once you enroll, contributions are deducted from your paycheck. You can make changes to the amount of your contribution at any time as your personal situation and needs change. The minimum contribution is $10 per pay period. The maximum contribution is 100% of includible compensation, up to $15,500 for 2007 if you are under age 50. If you are 50 or older, the catch-up provision allows you to contribute a maximum of $20,500 in 2007. If you are within three years of retirement, you may qualify to contribute more if you have past dollars to "catch up". For this pre-retirement window only, the maximum amount deferrable is the lesser of twice the normal deferral limit ($31,000) or 100% of includible compensation.

You have more than 35 investment choices as well as a Personal Choice Retirement Account through Schwab if you have at least $5,000 on account. As an added bonus, your money is available to you upon separation from County service with no early withdrawal penalty. Funds are also available for withdrawal for a financial hardship as defined by the IRS or through the loan provision where you can borrow up to 50% of the value of your account with a minimum of $1,000.

To request a consultation with a retirement specialist, contact NRS at 602-266-2733. For general information, call customer service at 800-598-4457, visit their Web site at ***www.maricopadc.com*** or stop by the NRS office located at 4747 N 7th Street, #418, Phoenix, AZ 85014.

METLAW® GROUP LEGAL SERVICES

Administered by MetLife through Hyatt Legal Plans

Finding an affordably priced lawyer to represent you when you have trouble with creditors, buy or sell your home, or even prepare your will can be a challenge. Now there's a simple, affordable solution. MetLaw is a legal services plan that provides legal representation for you, your spouse and dependents at an affordable price.

Now you have a resource at your fingertips for important, everyday legal services. What's more, you'll also have someone to turn to for unexpected legal matters. With MetLaw, you can receive legal advice and fully covered legal service for a wide range of personal legal matters, including:

- Court Appearances
- Document Review and Preparation
- Debt Collection Defense
- Wills
- Family Matters
- Real Estate Matters
- Traffic Ticket Defense (except DUI/DWI)

This is just a partial list of services. For more information contact Hyatt Legal Plans at 800-821-6400 or online at ***www.legalplans.com*** (password 1500518).

Services are provided from a network of experienced attorneys either on the phone or in person. When you use a Plan Attorney, there are no deductibles, copays, waiting periods, claim forms or limits on usage. You also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule.

The premium for this plan is $7.87 per pay period, 24 pay periods per year.

AUTO, HOME AND RENTERS INSURANCE

Fully Insured by Liberty Mutual

As a Maricopa County employee, you qualify for a special group discount* on your auto, home and renters insurance through Group Savings Plus® from Liberty Mutual. With Group Savings Plus, you can enjoy the ease and convenience of paying your premiums through payroll or checking account deductions, with no down payment or finance charges. You also will enjoy fast, easy, round-the-clock claims service and a variety of discounts for multi-car, multi-policy, safe-driver, passive restraints and anti-theft devices.*

See for yourself how much money you could save with Liberty Mutual compared to your current insurance carrier. For a free, no-obligation quote, call 800-524-9400 or visit ***www.libertymutual.com/lm/maricopacountyemployees***.

*Discounts and credits are available where state laws and regulations allow and may vary by state. Certain discounts apply to specific coverage only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage is provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.

COMBINED PREMIUM SHEET

Pay Period Total Medical Premium for Non-Tobacco User Households

(Includes medical, pharmacy, behavioral health and vision)

Premiums are deducted from the 1st and 2nd pay period of the month. (24/yr.)

Add $10 per household for tobacco-users (employees and/or covered dependents)

CMG High option + Co-insurance Rx	Full-time	Part-time
Employee	$10.46	$94.14
Employee + Spouse	$30.28	$108.10
Employee + Child(ren)	$18.62	$103.20
Employee + Family	$50.18	$117.24

CMG High

CMG High option + Consumer Choice Rx	Full-time	Part-time
Employee	$5.48	$89.16
Employee + Spouse	$20.42	$98.24
Employee + Child(ren)	$11.22	$95.80
Employee + Family	$35.38	$102.44

CMG Low option + Co-insurance Rx	Full-time	Part-time
Employee	$4.98	$4.98
Employee + Spouse	$26.10	$26.10
Employee + Child(ren)	$16.30	$16.30
Employee + Family	$42.62	$42.62

CMG Low

CMG Low option + Consumer Choice Rx	Full-time	Part-time
Employee	$0.00	$0.00
Employee + Spouse	$16.24	$16.24
Employee + Child(ren)	$8.90	$8.90
Employee + Family	$27.82	$27.82

OAP In-Network + Co-insurance Rx	Full-time	Part-time
Employee	$16.14	$95.46
Employee + Spouse	$61.20	$109.58
Employee + Child(ren)	$44.08	$104.62
Employee + Family	$90.98	$118.82

OAPIN

OAP In-Network + Consumer Choice Rx	Full-time	Part-time
Employee	$11.16	$90.48
Employee + Spouse	$51.34	$99.72
Employee + Child(ren)	$36.68	$97.22
Employee + Family	$76.18	$104.02

OAP High option + Co-insurance Rx	Full-time	Part-time
Employee	$18.38	$110.94
Employee + Spouse	$68.90	$127.32
Employee + Child(ren)	$49.72	$121.58
Employee + Family	$102.48	$138.06

OAP High

OAP High option + Consumer Choice Rx	Full-time	Part-time
Employee	$13.40	$105.96
Employee + Spouse	$59.04	$117.46
Employee + Child(ren)	$42.32	$114.18
Employee + Family	$87.68	$123.26

OAP Low option + Co-insurance Rx	Full-time	Part-time
Employee	$9.22	$76.72
Employee + Spouse	$26.10	$88.12
Employee + Child(ren)	$16.26	$84.14
Employee + Family	$42.74	$95.62

OAP Low

OAP Low option + Consumer Choice Rx	Full-time	Part-time
Employee	$4.24	$71.74
Employee + Spouse	$16.24	$78.26
Employee + Child(ren)	$8.86	$76.74
Employee + Family	$27.94	$80.82

Choice Fund HSA + CIGNA Rx	Full-time	Part-time
Employee	$8.82	$85.40
Employee + Spouse	$24.92	$98.10
Employee + Child(ren)	$15.54	$93.64
Employee + Family	$40.56	$106.44

Choice Fund HSA

FY 2007-2008 PAYROLL SCHEDULE
USED FOR BENEFIT PREMIUM CALCULATIONS, COVERAGE EFFECTIVE DATES AND COVERAGE END DATES

	Beginning	Ending	Pay Day
1	June 18, 2007	July 1, 2007	July 6, 2007
2	July 2	July 15	July 20
3	July 16	July 29	August 3
4	July 30	August 12	August 17
5	August 13	August 26	August 31
6	August 27	September 9	September 14
7	September 10	September 23	September 28
8	September 24	October 7	October 12
9	October 8	October 21	October 26
10	October 22	November 4	November 9
11	November 5	November 18	November 21
12	November 19	December 2	December 7
13	December 3	December 16	December 21
14	December 17	December 30	**January 4, 2008**
15	December 31	January 13	January 18
16	January 14	January 27	February 1
17	January 28	February 10	February 15
18	February 11	February 24	February 29
19	February 25	March 9	March 14
20	March 10	March 23	March 28
21	March 24	April 6	April 11
22	April 7	April 20	April 25
23	April 21	May 4	May 9
24	May 5	May 18	May 23
25	May 19	June 1	June 6
26	June 2	June 15	June 20

HOLIDAY SCHEDULE

	2007	2008
New Year's Day	Monday, January 1	Thursday, January 1
Martin Luther King Jr./Civil Rights Day	Monday, January 15	Monday, January 21
President's Day	Monday, February 19	Monday, February 18
Memorial Day	Monday, May 28	Monday, May 26
Independence Day	Wednesday, July 4	Friday, July 4
Labor Day	Monday, September 3	Monday, September 1
Columbus Day	Monday, October 8	Monday, October 13
Veteran's Day	Monday, November 12	Tuesday, November 11
Thanksgiving Day	Thursday, November 22	Thursday, November 27
Christmas Day	Tuesday, December 25	Thursday, December 25

ONLINE EMPLOYEE SELF SERVICE INSTRUCTIONS

more detailed instruction are available on the EBC intranet at:
http://ebc.maricopa.gov/training/OLL/peoplesoft.asp

1. Start your browser by double clicking the  on your desktop.

2. In the address line in the browser, type my.maricopa.gov and press “Enter” on the keyboard

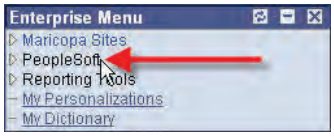
-or

from work, access the Intranet click on the My.Maricopa.Gov button at the top of the EBC home page (*http://ebc.maricopa.gov*)

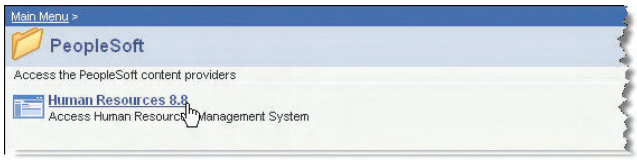
3. At the initial PeopleSoft login screen, enter your user ID and password and click the “Sign In” button or hit “Enter” on the keyboard.

(if you do not know your ID or Password, call your department PC Help Desk or the Customer Support Center at 602-506-4357)

4. After successfully logging in, click on “PeopleSoft” located in the menu on the left of the page.

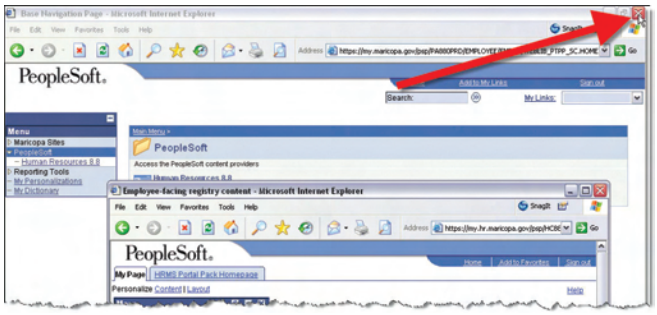


5. Click on “Human Resources 8.8”



6. A new PeopleSoft page will open.
Close the first window.

If you do not close the initial PeopleSoft page, you will be timed out after 20 minutes and may lose your selections.

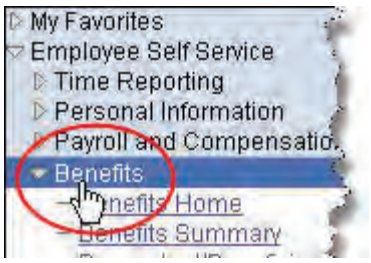


7. You now have one PeopleSoft page open with a Menu similar to the one displayed. You may need to enlarge the page to fully view the menu and options (Press F11 on your keyboard to view the page full screen).

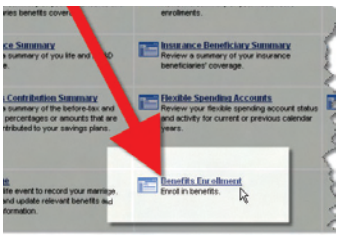
8. At the Menu...

Click on “Employee Self Service”

Click on ‘Benefits”



Click on “Benefits Enrollment”



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9. You may now begin the Enrollment process. To begin, click on the “ Select ” button.

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10. Go through each option listed in the Enrollment Summary in the order they are listed. To view your medical and other benefit options, click the “Edit” button to the left of each option.

11. Make sure to review the “TOBACCO USE” benefit and answer the question accurately. This is the area where you indicate your eligibility for the NON-TOBACCO USER incentive.

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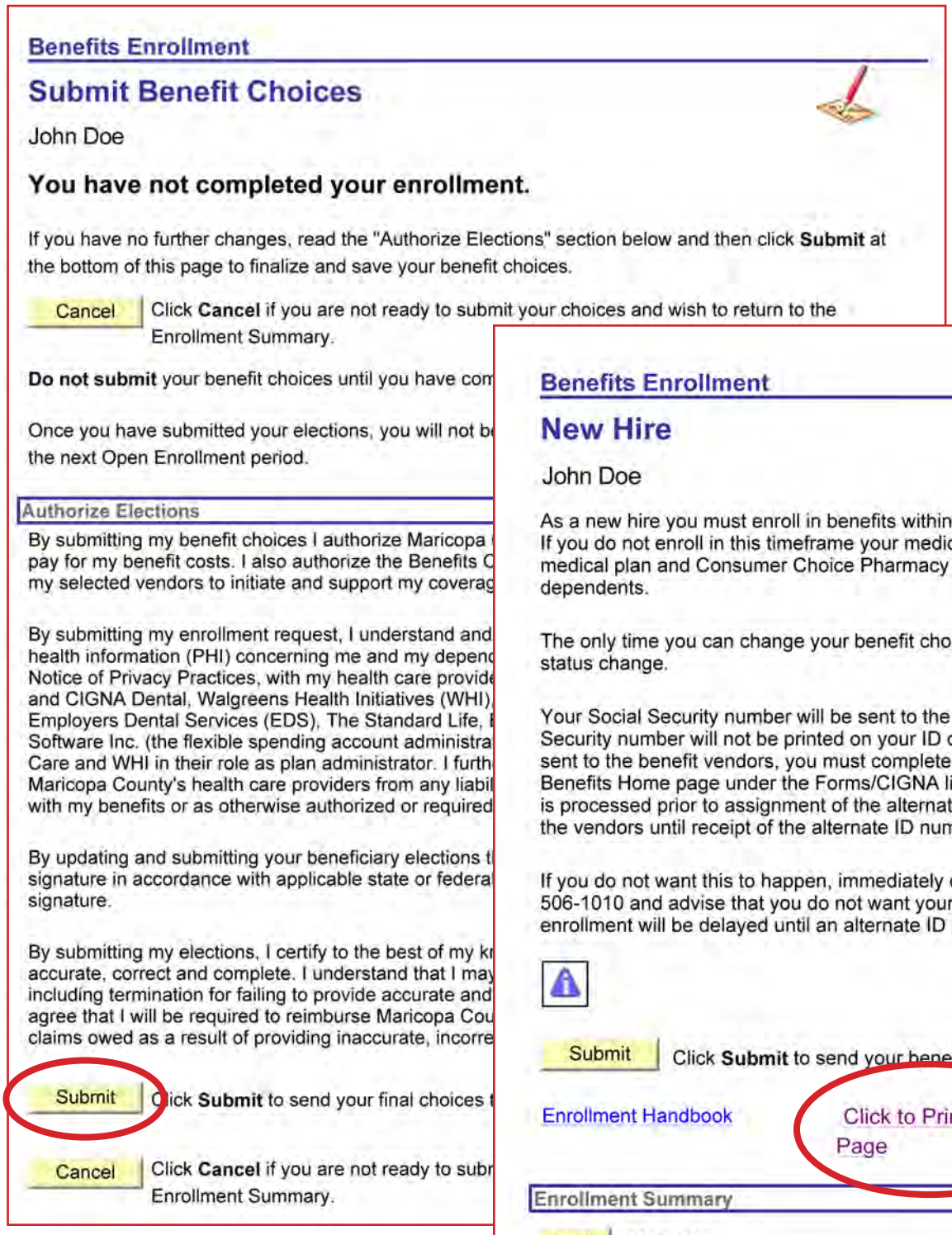
12. You must click on **two “SUBMIT” buttons** to complete your enrollment. After making all benefit elections, click on the “Submit” button at the bottom of the page. On the next page, click on the “Submit” button at the bottom of the page to send your final choices to the EHI Department.

EXAMPLE



13. **Once you have submitted your final benefit elections, go back into your New Hire event and "print" the benefit enrollment summary page so you will have verification of your benefit elections. Use the printed summary page to compare to the confirmation statement you will receive from your department's HR Liaison. In case of an error, you can use the printed enrollment summary page to have your benefits corrected.**

WHO TO CONTACT

Maricopa County Employee Health Initiatives Department
(Benefits Office)
Maricopa County Administration Building
301 West Jefferson St., Suite 201
Phoenix, Arizona 85003-2145
(602) 506-1010
Fax: (602) 506-2354
EHI Home Pages { *www.maricopa.gov/benefits* / *http://ebc.maricopa.gov/ehi*
BenefitsService@mail.maricopa.gov

Medical Plans

CIGNA - Group #3205496
Customer Service - (800) 244-6224
Pre-Enrollment Questions - (800) 401-4041
24-Hour Health Information Line - (800) 564-8982
Well Aware Disease Management - (800) 249-6512 to enroll
or (877) 888-3091 for questions
Healthy Babies - (877) 244-6224
Healthy Rewards - (800) 870-3470
www.cigna.com
www.mycigna.com
www.mycignaplans.com
(username: Maricopa2007 / password:cigna)

*Pharmacy Plans**

Walgreens Health Initiatives - Group #512229
Member Services - (800) 207-2568
Prior Authorization - (877) 665-6609
Walgreens Mail Service Member Service - (888) 265-1953
Mail Service Refills - (800) 797-3345
Specialty Pharmacy - (888) 782-8443
www.mywhi.com

*Behavioral Health / EAP**

Magellan Health Services - Group# N/A
(888) 213-5125
www.magellanhealth.com

Vision

EyeMed Vision Care - Group #9690793
Customer Service - (866) 724-0782
Pre-Enrollment Questions - (866) 723-0596
LASIK - (877) 552-7376
www.eyemedvisioncare.com
emvision@eyemed.sento.com

Dental

Employers Dental Services - Group #11931-Plan #300
(602) 248-8912 or (800) 722-9772
www.mydentalplan.net

CIGNA Dental - Group # 2465354
(888) 336-8258
www.mycigna.com

Delta Dental - Group # 4500
(602) 938-3131 or (800) 352-6132
www.deltadentalaz.com

*Contact CIGNA for pharmacy & behavioral health for the Choice Fund HSA plan

Life Insurance

The Standard - Policy #645547
(888) 414-0396
www.standard.com/mybenefits/maricopa

Short-Term and Long-Term Disability

Sedgwick CMS - Group# 435000
Short Term Disability - (800) 599-7797
Long Term Disability - (800) 495-9301
www.sedgwickcms.com/calabasas

Retirement

Arizona State Retirement System - (602) 240-2000
Outside Phoenix - (800) 621-3778
www.azasrs.gov/web/index.do

Public Safety Retirement System
(602) 255-5575
www.psprs.com

Nationwide Retirement Solutions:
Deferred Compensation
(602) 266-2733
(800) 598-4457
www.maricopadc.com

Other

ASI - Group #455
Mariflex (Flexible Spending Accounts)
(800) 659-3035
www.asiflex.com
asi@asiflex.com

Liberty Mutual: - Group #8871
Auto, Home and Renters Insurance
(800) 221-8135
www.libertymutual.com

MetLaw® - Plan 150 / Group #0518
(800) 821-6400
www.legalplans.com *(password - 1500518)*

Compusys
COBRA Administrator
(602)-234-0497
(800) 933-7472
mccobra@compusysaz.com